DOCUMENT RESUME

ED 107 538 SO 007 921

TITLE	Institute on Human Values in Medicine. Proceedings of the Second Session, April 26-28, 1972.
INSTITUTION	Society for Health and Human Values, Philadelphia, Pa.
SPONS AGENCY	National Endowment for the Humanities (NFAH), Washington, D.C.
PUB DATE	72
NOTE	166p.; For related documents, see SO 007 920-922, 934, and 935; Not available in hard copy, Out of Print
EDRS PRICE	MF-$0.76 HC Not Available from EDRS. PLUS POSTAGE
DESCRIPTORS	Curriculum Development; Ethical Values; *Health; Higher Education; Humanism; Humanistic Education; Humanities; *Humanization; Interdisciplinary Approach; *Medical Education; *Medicine; Program Descriptions; *Values

ABSTRACT

This document reports on the second session held by the Society for Health and Human Values. The aim of the meeting is to concentrate on specific measures for achieving a human-values orientation within the varied settings of medical education. Specifically, the following questions are raised: Why human values studies in medical education? How are matters concerning human values best taught and learned in medical education? What are the resources and impediments both inside and outside the institution? In the first presentation, "The Liberation of Imagination" the author suggests that the problem is theoretical -- that what is being sought is a new kind of intelligence. "Medicine and Humanism: Evolution in Process," the second presentation, proposes that those in medicine must learn to cooperate together, as do those in the larger fields by human endeavor. Group reports are included which focus on the rationale, process, and context for teaching human values in medical schools. The document concludes with background papers prepared for the second session of the institute which are self-descriptive reports of human values teaching in 11 program schools of medicine. (Author/JR)

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Institute on Human Values in Medicine

PROCEEDINGS OF THE SECOND SESSION

ED 107538

Society for Health and Human Values

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Institute on Human Values in Medicine

PROCEEDINGS OF THE SECOND SESSION

Conference Center, Williamsburg, Virginia
April 26-28, 1972

Society for Health and Human Values

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Funded by the National Endowment for the Humanities - Grant No. EO-194-70-4163

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(1971-1972)

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WELCOMING REMARKS

William F. Maloney, M.D.

Dean of the School of Medicine, Tufts University
President, Society for Health and Human Values

Ladies and gentlemen, welcome. Your presence here this afternoon is quite a tribute to our speakers, in view of the superb weather outside. But I believe it is a deserved tribute, since we are graced on this occasion with some excellent speakers as well as a grand background and setting.

Although I know that the material sent to you prior to this conference contained background information about the Institute, I think it might be helpful to draw some distinctions between the Society for Health and Human Values and this Institute on Human Values in Medicine.

The Society for Health and Human Values began to develop in late 1962 and early 1963 through dialogues between some medical educators and some theologians, especially those who were at that time active in higher education. They formed a Committee on Health and Human Values which, after four years of informal discourse, formalized its existence by forming this Society for Health and Human Values. Thus in 1969 this organization came into being. It is an invitational society whose membership is purposely small at this time (approximately one hundred), but we hope that as we establish a solid base and develop a well defined program, there will be significant expansion of the Society's activities and membership.

The purpose of the Society is to create a forum in which some of the issues and value-problems that are confronting medical education can be discussed and examined in a national context. The Society has functioned as a sponsor of various projects that have been funded with outside support. This Institute is one such project; it is supported by the National Endowment for the Humanities.

The Society is sponsor also of four other projects. One has explored the issues surrounding human experimentation, and another has dealt with the expectations of consumers in regard to their health care. I can recall that when we talked this over at one time with a member of the Society, he suggested that maybe what we were really doing was preparing to re-write the Hippocratic oath. At any rate, this had developed into a very interesting exploration of dimensions that have never been really sought before in regard to measuring what values people hold, and what they expect from the health care system.

A third project, which has just begun, concerns the role of women in the health sciences. Our fourth project reflects the early history of this group in that it is a study of the relationship between the campus ministry and the colleges of medicine. From the beginning, administrative support for the Society has been provided by the United Ministries in Higher Education, while financial assistance has come from the Russell Sage Foundation, the Danforth Foundation and Health Services and Mental Health Administration, in addition to this Institute's support from the National Endowment for the Humanities.

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The Society has had three previous presidents: first George Wolf, then Ed Pellegrino, and last year Al Vastyan. I am serving as president currently, with the assistance of our Executive Council, which coordinates and plans our activities. We have also an Executive Director, Ron McNeur, and for this particular project Lorraine Hunt is serving as Project Director for the Institute on Human Values in Medicine.

The Institute is now in its second session. The first session, which occurred a year ago, addressed certain questions related to the matter of human values in medical education, and considered ways in which human values might be promoted through a cooperative relationship between humanists and medical educators. To a considerable degree, the work of the first session was as much to define the relevant questions as to ask them. As Chairman of the Institute, Ed Pellegrino opened the first session by suggesting some of these questions--you may recall them from his opening address, which is printed in the Proceedings of the First Session:

> "Is there a problem in medical education that is appropriate for this group to address? Is there a need for better interpolation of the knowledge of the humanities within the framework of education in all of the health professions? If so, what is it that we mean and seek? What are our goals, and are the methods we are now using to achieve them satisfactory? Can we improve on these methods? Is there interest among humanists in working with us in the health professions toward some future defined goal?"

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While most of the participants in the first session were humanists, the "faculty" of this session consists primarily of medical educators. However, to promote continuity from the first conference to this one, we have asked a number of individuals who participated in last year's session to attend this one, also. They will help us go forward from the conclusions of the first session, which defined pertinent issues and identified mutual needs and potential benefits.

The aim of this meeting, then, will be to concentrate on specific measures for achieving a human-values orientation within the varied settings of medical education. As the agenda indicates, you will be asked to respond as concretely as possible to the difficult questions of <u>why</u>, <u>how</u>, and <u>what</u>: why human value studies in medical education, how are matters concerning human values best taught and learned in medical education, and what are the resources and impediments both inside and outside the institution?

Further explanation of the intent of these discussions will be provided by the Institute's leaders and Chairman, Ed Pellegrino.

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THE LIBERATION OF IMAGINATION

Michael Novak, Ph.D.

Associate Professor of Philosophy and Theology
State University of New York at Old Westbury

Looking backwards at the First Session of this Institute, and looking ahead, the same theoretical problem meets us and must be cracked.

It would be tempting to say that our task is a practical one; viz., to design effective curricular for the study of human values in medical education. It would even be tempting to say that our problem is a political one; viz., to persuade schools of medicine that humanistic studies must have a larger share of time, money and status. These are real problems, the practical and the political ones. But they are not the fundamental problem.

The fundamental problem is theoretical. We need to elicit in ourselves a new kind of intelligence. If you will permit me, I will give a name to the X we are looking for. I call it "intelligent subjectivity." It is not the same as medical, scientific intelligence. It is not the same as professional humanistic intelligence.

It is plain that some new sort of intelligence is required if we reflect for a moment on the inadequacies of the forms of intelligence we now practice. Medical professionalism, I take it, disciplines attention. It focuses upon the disorders of certain human functions and structures. It tends to abstract from cultural, social and psychological realities. It does so for the sake of the power it thereby achieves. But it does so.

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Something similar is true of humanistic professionalism. College presidents like to say that studies in the professions of the humanities "humanize" students. But what if studies in such professions merely "professionalize" students? Does writing an A+ paper on the hidden homosexual tendencies of Gustav Flaubert, which a T.A. says is so good "it should be published," make a student of the humanities less professionally focused than a student of medicine? A lot depends on who is teaching the student, and what the student is like. So far as professionalism goes, how humanistic a man's perceptions or actions are is irrelevant. For the humanistic professions have, to a deplorable degree, imitated as best their material allows the "rigor," "quantification," and "conceptual clarity" of the sciences. It is as important for humanists to be "hardheaded," to have "hard" data, to formulate "hard arguments" as for scientists. The dream of every professional, it seems, is to be "tough-minded." (Gangsters, soldiers and businessmen may have had more influence on our sense of reality than we think.) Professionals, it seems, compete to be thought masculine.

It is true, that medical professionals tend to find the humanists too allusive, unwilling to come to conclusions, unclear. And humanists worry professionally about a larger, more elusive range of "values" than medical professionals, qua professionals, do.

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Now it is possible that humanistic professionals working with medical professionals might create a new universe of professional discourse: something like "bio-ethics," a study of the value questions in everything having to do with life and health. In addition, it is possible that teams of humanists and doctors, working in clinical situations, might build up a body of reflective doctrine that would serve to guide future practice in concrete dilemmas. May both of these developments proceed rapidly. Even if both are successful, we will find that we have, without noticing it perhaps, developed a new kind of intelligence. Such an intelligence will not be exactly medical, nor exactly humanistic, nor exactly professional. It will be wide-ranging, because the kinds of concrete dilemmas it faces are wide-ranging. It will be personal and concrete, for the problems it addresses inhere in concrete persons in their concreteness and in their personhood. It will be "intelligent" because it will be aware of alternatives, self-critical, and inventive. It will be a form of "subjectivity" rather than a form of "objectivity," because it will be based in changes brought about in its subject's consciousness and ways of perceiving. It will not be easy to routinize or to quantify. The checks placed upon it will arise from inter-subjective consultation and mutual criticism.

If I may, I would like first to develop a few broad strokes of historical background. Then I would like to specify some of the

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skills involved in the development of intelligent subjectivity in oneself, and in respect for it in others. Finally, I would like to propose some ways of acquiring, teaching and reinforcing those skills.

1. A Historical Note

The historical note must be rough and brief. I want to begin by distinguishing "technical intelligence" from "liberal intelligence." Technical intelligence derives from the conviction that knowledge is power. Technical intelligence is the practical expression of the scientific enterprise. As science aims toward human mastery of world and self through expanding our powers of prediction and control, technical intelligence is the working out of the practical problems in that enterprise. It is problem-solving intelligence. It breaks problems into their components, figures out their functional relations, places them under schemes of prediction and control, and thus reduces them to human power. It is, in this sense, manipulative, but with the highest intentions and most noble aspirations. It manipulates, but for human welfare.

By contrast, the liberal tradition develops with the developments of Western thought, partly in opposition to and partly in symbiosis with, technical intelligence. While science and technique address soluble problems, we might say, liberal intelligence, drawing upon cultural resources that both antedate and postdate the rise of the scientific attitude, deals with "the larger questions" that science

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does not address. For some persons, like B. F. Skinner, there is always the hope that science will one day get around to these questions, and solve them better than the humanists have done. For them, liberal intelligence is a holding action, a residual category, a category that is always shrinking; it troubles itself with those matters science has not yet taken up. For other persons, the role of science is not to provide a whole vision of human life, but to cope instrumentally with grievous and important problems in the way of human survival. Science is not so much a vision as a tool.

The liberal tradition in any case, had its greatest and most recent formulation at the time of the Enlightenment. Liberalism there took on a missionary concern implicit in its commitment to certain universal values based on Reason. One sees this metaphorically in the very notion of "Enlightenment." It is not such a bad thing to be "enlightened." Implicit is a separation of people into the elite and the herd, the enlightened and the unenlightened. The social institution of enlightenment is the university. It becomes the task of graduates from the universities to help "enlighten" the populace, to promote literacy, to encourage the development of "enlightened" values. These values include those specified in K. Danner Clouser's paper at the first Institute, like the doctrine of least suffering, but also notions of liberty, dignity and justice as these have developed in our particular culture.

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In the liberal tradition, Reason is an important symbol, a symbol of something universal and proper to all humans. On its possession is based their dignity and radical equality. But Reason is also a symbol for social revolution. It points to a world order based upon Reason. It operates as a weapon against traditions, rituals, habits, practices, families, historical loyalties. Students are taught to bring all these "into question." They learn not to trust traditions. To be called a traditionalist is not usually a compliment. In every possible way, partisans of Reason weaken the hold of the past. The metaphor of "enlightenment" is aimed against the forces of the status quo, and at its critical best is put in the service of equality and justice.

There was conflict as well as confluence between liberal intelligence and technical intelligence. For a long time in our culture they have operated as allies. Argument, debate, and criticism fly back and forth. They compete. Some of those we call Romantics side with liberal intelligence over against technical intelligence and its "progress;" Ruskin in England, Henry Adams on "The Dynamo," for example. Pascal, a lineage is passed on through Dostoyevsky and Camus, arguing that "the geometric spirit," the "hard-nosed" men who believe that "2+2=4," will end by destroying everything human. Listening today to talk of ecological disaster, atomic warfare, napalm, a crisis in medical ethics, they might say -- not with pleasure, but in anguish: "We tried to tell you so." They were against linear thinking, against ideas so

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"clear and distinct" they distorted the thickness and tangledness of being human. This tradition became known as Irrationalist, but it was, rather, counter-Rationalist. It was skeptical of progress through Reason.

Generally, however, the Irrationalist movement made little headway in America. In America, the liberal tradition has been remarkedly benign, remarkably optimistic, quite at home with the fruits of scientific progress and the spirit of technical intelligence. As I suggested earlier, it is probably true that technical intelligence dominates the humanities quite as much as it dominates medicine. The materials are more resistant, the number of viewpoints is higher, the systems of analysis multiply. But rigor and conceptual clarity rule. There are social, economic, cultural reasons for the triumph of the technical.

In the United States, the large corporations and economic interests have generally been in favor of civil rights, equality, literacy. A technically sophisticated population, of fairly homogenized culture and standards, is economically significant, even critical. Technical intelligence, then, fulfills the symbol of universal Reason so important to the liberal tradition. Reason comes to be institutionalized in O'Hare terminal, in Houston, in Dallas, and in other new, technological cities.

And thereby is revealed the new, widening split between technical intelligence and liberal intelligence. All of a sudden, many sensitive spirits are less comfortable than they used to be about the earlier union of the two. High value was placed on value-free discourse and quantified thinking with clear, distinct, isolated ideas. Certain systemic, social disorders have cast doubt upon that model of thinking.

The shock of Vietnam has been helpful -- if we may be permitted to draw good out of a painful evil. As some intelligent Vietnamese see it, American conduct in Vietnam is the best fruit of American intelligence. This war is the first Vietnamese have ever encountered (perhaps the first ever fought by) thoroughly "hard-nosed" calculations, strategies, and weaponry. (Called "hardware.") It seems to them that everything countable has been counted in Vietnam, by sociologists, economists, demographers, agricultural chemists, political scientists, military experts. On Vietnam, Americans have mountains of hard data. Vietnam is more than any other in our history a realist's war, fought with the realist's methods. But American technical intelligence seems to some Vietnamese a most incomprehensive mysticism, a mysticism of mathematics. It is as if Americans believed that through the accumulation of hard data, thorough counting, they could understand a culture, a politics, a people. The human reality of Vietnam -- its many cultural streams, its languages, its traditions,

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its philosophers, its heroes, its folk songs, its poets, its rituals, its virtues and symbols -- escapes American attention and even interest. Americans know pitifully little about the cultural texture of Vietnam, care even less.

Not least because of Vietnam, merely technical intelligence has come under severe criticism in America. The whole record of technical intelligence has come under examination: in social science and in "social engineering;" in auto manufacturing; in law; in the physical sciences; in medicine. We all feel the surge toward systemic and value-laden thinking. And that sort of thinking, especially in its originative moments, depends heavily on the intuitive, perception-guiding parts of a human being. To state one's values one needs more than a descriptive, quantifiable usage of words or concepts or discursive maneuvers. One must be able to direct the other's attention, guide his perception, show him how to see as oneself sees. Linguistic structures I may have for expressing my values are, secondly, always open to amendment because my values have yet further situations to meet, under new interpretive structures. Intelligent subjectivity is a sensitive instinct for what cannot yet be said -- a sense of groping, exploring, reaching. It is a kind of anti-dogmatism. It is based, not on value-free skepticism, but on value-laden self-questioning and self-criticism. Its best check is intersubjective correction and challenge.

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2. The Skills of Intelligent Subjectivity

By "intelligent subjectivity," I mean something like the bent, cast, direction of a human's capacity for noticing, or for raising questions. I stress "noticing," because often we miss what is right in front of us; we take things for granted, see only in routine ways. "Noticing" is the most ordinary and common form of awareness taken by an inquiring person. "Raising questions" is not so much a matter of putting interrogative sentences into words, as it is a matter of disciplining one's attention to sharper than pedestrian awareness.

"Intelligent subjectivity" is composed of many skills. I use the word "intelligent" in order to stress the self-critical, corrigible, inquisitive character of the disciplined human development I am speaking of. I use "subjectivity" in order to stress the uniqueness of this development in each person. Each person is a different who: has a unique genetic character, a unique personal history, a uniquely assimilated set of values and directions: has a unique sense of reality, lives out a unique personal story, is moved by a unique configuration of symbols. By the word "subjectivity," I want to stress that the intelligence of each of us is particular, concrete, personal. By the word "intelligent," I want to stress that our uniqueness is not an occasion of darkness and irrationality, but a resource full of concrete light and illumination. It is not true that one's intelligence becomes sharper only in proportion as one becomes more "objective" and

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thus is a position to be like all other similarly motivated individuals. It is, rather, true that one's intelligence becomes sharper as one "appropriates" one's own subjectivity: learns the resources, capacities, potentials and limits of one's own unique standpoint. We do this best under intersubjective challenge, in which our finitude becomes painfully clear.

One of the tasks of medical education (of education in every profession) is to show students the limits of the professional standpoint. The whole point of an educational system is to discipline attention and procedures; to enforce a specialization of human perception and action. Given the enormous undifferentiated range of human possibility, one chooses a finite set of skills and directions. Professionalization, therefore, is much more like a sectarian religion than we commonly notice. It inculcates a new "sense of reality," with its specified criteria of relevance and evidence. It teaches a new way of spending one's years -- a career, a course to run, a story to live out. It is governed by codes, peer group pressures, status and other rewards: i.e., by a highly developed, highly precise, highly effective symbol system.

Professional education is not, however, a long-established phenomenon; it is of relatively recent power and effect -- everyone remembers the more casual, more generalistic, more "amateurish" years of yesteryear, and the onset of strict professionalization can be dated almost to the hour in many now highly disciplined fields. Thus

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the critique of professionalization now arising is not, after all, far behind schedule. The various professions have had just enough time to lose contact with one another, to blossom in the full glory of sectarian isolation, and to realize suddenly that each is alone, naked, and shivering in full sight of an anxious population of non-experts.

The task of medical education, I repeat, is to awaken students early to the limitations of professionalism -- to warn them early of the sectarian narrowness they are about to acquire, as the price of the power they exercise. The task is to give them skills in self-criticism, so that they will not be captive of their own professionalism. The captivity of the professional humanist is just as commonplace. As humanists, many are superb technicians. We must now enumerate the skills of self-liberation.

First, it is critical for the student to learn something that is obvious in theory, but elusive in personal acquisition: an effective shock of recognition that one's own sense of reality is not coextensive with reality; a deep, psychic jolt conveying that one's own consciousness is no longer, for oneself, the center and pivot of the universe. One becomes effectively aware of the uncertainties and limits inherent in having but one standpoint among countless possible ones. All enlightened people "know" this, in principle. The test of whether they know it <u>effectively</u> is how sympathetic they are to standpoints contrary to theirs. It is

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crucial that they be able to grasp the plausibility of ways of perceiving that are the polar opposite of their own. If they cannot do that, their own sense of reality has become much more fixed, stable, and normative than it ought to have.

This is, I know, a harsh test. It consists of taking the standpoint you consider most hostile to your own, and learning to feel its power, plausibility, and strong points so vividly as be able to recreate them in description and in argument, as a proponent might. One does this tentatively, of course, and without commitment. But one does "cross over" into the opposite standpoint. It is a form of "loving your enemies as yourself." And it is a great discipline for one's own intelligent subjectivity.

The most direct assault upon intelligent subjectivity, however, is not quite so harsh. Indeed, it is often trivialized. Still, it is highly useful. It consists in replying to a simple question: "Who am I?" The most fruitful way to reply to this question, however, is to describe -- with neutrality and only the barest of interpretations, at first -- the five or six <u>experiences</u> in one's life that, in one's own estimation, have been most determinative of one's own identity. The emphasis is upon <u>experience</u>, not upon labels, or interpretations, or wishes, or ideologies, or beliefs. Then comes the second step. Why these experiences, and not others? What sort of person am I if <u>these</u> are the experiences I choose? And what do they mean -- how do I now interpret them? And why do I incline to the <u>sorts</u> of interpretation I do?

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The reason for stressing the importance of experience in responding to the question "Who am I?" is twofold. First, our culture tends to have a bias toward concepts and words. Before we have experiences, we commonly have six theories by which to describe them. Sometimes, young people who do not have the experiences talked about in prevailing theories -- "identity crisis," e.g. -- think something must be wrong with them. Secondly, stress on experience reveals to future-oriented young people the power of their personal past. It teaches them their uniqueness. It disallows them to accept as routine or universal their own unique experience. It may give them ears for detecting signals from the unique history of others.

The third skill implicit in intelligent subjectivity is learning to detect where the "sense of reality" of others differs from our own. It is not true that we all live in the same conscious reality; we each perceive differently. It is as though each of us were within a separate little cloud of awareness, each in our personal yellow submarine, having contact and overlap at some places, but strangely divergent from and foreign to each other at other places. Learning to listen for differences sympathetically is an art. What is real, significant, meaningful, relevant, evidentiary for some is dismissed as unreal, unimportant, trivial, irrelevant, and illusory by others. The imaginative structures through which we perceive pain, loneliness, community, birth, death, suffering, technique, machines, experts, etc.

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differ enormously from ethnic heritage to ethnic heritage, person to person. Our most spontaneous and long-lived perceptions may be exactly the reverse of those of others -- and not least in the areas of life, health, illness, and death.

In a sense, no profession so cuts across the fundamental experiences of life as medicine. Yet each of those experiences is perceived through unique symbolic structures by different cultures and different persons. Medicine, in this sense, is a "superculture" of technique and professionalism superimposed upon subculturally variant perceptions of fundamental experiences. The fourth skill implicit in intelligent subjectivity, therefore, is to bring to awareness one's own personal symbolic structures. How have I been taught to experience and to feel life, pain, health, death? Not how do I think about them. But how my experiences and feelings tend to take shape. Is it all right for me to cry out or make a fuss when I'm in pain? Or is it my feeling that silence is more noble? Is illness an invader from outside? An "outside agitator"? Or as much a part of me as my breathing? Is pain merely an unpleasantness to be removed? a signal? a call to combat? a test? a quickly dispensable blemish and inconvenience?

In the face of those human predicaments that call the profession of medicine into existence, each cultural tradition has shaped human expectations differently. We do not have the same experiences. The imaginative structures we bring to similar situations diverge. Our experiences are different.

American education is highly verbal, conceptual, analytic. Almost all testing concerns two skills chiefly: the accumulation of information, the analysis of information. Our educational institutions allow human skills of imagination, discernment, sympathy, insight into other personalities and cultures, alertness to the uniqueness of experience and the like, to atrophy. This is the radical reason why the humanities are so weak in their response to the needs of medical education. Young doctors need a wide range of sympathies and swift discernments from very few cultural and personal signals. But these capacities have been neglected for so long in all of us that bringing them to vigor again will require long therapy.

I have listed four skills implicit in intelligent subjectivity: the effective grasp of the finitude and angularity of one's own standpoint; the effective awareness of one's own limited personal history, and an openness to noticing that of others; an effective discernment of "senses of reality" different from one's own; and, finally, an effective awareness of those culturally derived symbolic structures of one's own perception and imagination, which determine the shape of personal experience. All four of these skills aim rather at our imagination than at our conceptual skills. They teach us how to make our imaginations as analytic, so to speak, as our conceptual intellect -- to be as alert to nuances of image and experience, as to nuances of definition and description. Education of the imagination is, I believe, the heart of a profound education in the humanities.

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3. How to Teach These Skills

The question "how to..?" is different from the question "who..?" The fundamental question of the humanities is "Who are we, under those stars? Who am I? What should I do? What may I hope?" The humanities are concerned with identity, communal (the whole race of humans) and personal. The professions - even the professions of the humanities - are concerned with "how to..?" They are guilds for the development of techniques that bring destiny under human power. Humanists face a particularly difficult test of hypocrisy: will they become so preoccupied with the techniques of their craft that they themselves become tools, engineers, technicians - no longer in command of the who but defined by the how to? There is no general rule telling a humanist how to retain his own firm sense of who, while developing all his capacities for how to to their limit. Each must find his own way. The test lies in the ability of the man to make himself present to his materials with or without his techniques. That is to say, over and above his skills with techniques, one feels in him an open-endedness. The techniques so far developed are not ends in themselves. They are means. As attention is focused on the rich, inexhaustible, ever elusive realities of human life, and he is willing to learn even from the most unconventional and surprising courses.

Thus, pedagogy in the humanities is in part a matter of who and in part a matter of how to. In the humanities, there are many persons who are mere technicians. They may bring a certain new

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expertise to the medical school, but it is unlikely that they will make a dent in the malaise of mere professionalism; for they are carriers, too. Who one brings into a medical school is an important question. It is not simply a tactical question. The humanities are, in essence, a systematic concern for the who in human situations -- for the specifically human factors -- and if you bring in a distorted or poorly developed who, you distort the whole enterprise from the start. The person must show at least the sorts of skills we enumerated as proper to intelligent subjectivity. His capacity for "feeling his way into" entirely new standpoints, and for articulating the differences, is critical.

How do we train people to articulate the differences between standpoints, personal histories, senses of reality, and structural images? Practice, practice, practice. Words have to be invented, of course, for so accustomed are we to learning the skills required for "objective" argument that we fall strangely silent when called upon to articulate our own "subjectivity." It seems too private, too personal, too unimportant. We forget that our private lives are just as culturally shaped, just as communal, as our public lives. Little within us is less than banal, typical, ordinary -- and yet, for all that, it is unique in its configuration.

In humanities programs in medical schools thus far, it does seem by report that clinical situations, concrete cases, dilemmas that engage students in their subjectivity, are the pedagogical techniques

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deemed most successful. That is what my analysis would predict. What I wish to do is to legitimate with a theory what sound practice would surely lead us to. Medicine does engage humans intimately in one another's fate. The experiences which doctors and patients bring to their contacts diverge dramatically. What we need are methods for opening up those dramas to effective notice. They are there. How can we learn to "notice" them?

The first step is for the doctor to receive a jolt deep in his own identity, so that he does not feel comfortable being merely the expert, the professional, the skilled technician. Nor is it enough merely to smile and to be a nice guy, with a pleasant bedside manner. He needs skills for discerning early the unique personal drama in which the person he is with is caught. For the doctor is himself, now, a looming persona in that drama. The quality of the experience depends, in part, on what is happening in the patient's imagination and, in part, on what is happening in the doctor's imagination.

The only way I know of to bring students to consciousness of the dramas of personal identity is to direct their attention to them by entrapment. To assign them the task of putting their own sense of reality in words entraps them in the limitations of words, in the limitations of their own sense of reality, and in the limitations of their own self-consciousness. They are entrapped into the discovery of how little they know about themselves, and how different their awareness is from that of others.

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Clinical situations of various sorts entrap them into misperceptions of others, which the testimony of those concerned can be made to shatter. The skills of finding out how to "cross over" into another person's standpoint are learned, like most good things, through failure. Students can guess what other people feel about death, or family, or honesty, or pain. Then the others correct them. The complicated reality of "culture" -- shared perceptions, shared emotional patterns, shared expectations -- becomes dramatic when, in a pluralistic culture like our own, perceptions and expectations clash. We learn a new respect for one another's complexity.

Rather than by enumerating a full set of techniques for showing medical students how to come into conscious possession of their own intelligent subjectivity, and how to discern and to respect that of others, I would rather conclude by emphasizing the generative matrix from which such techniques may be invented: Bring to light the ways whereby imagination structures experience. Concentration upon the ways in which our imaginations differ from one another will shed more light upon our cultural, ethical and even intellectual differences than any other alternative. Imagination stands at the crossroads between experience and intellection, experience and passion, experience and revulsion. To devise ways by which students confront the activities of their own imagination, and those of others, is to introduce them by a powerful route into the dilemmas of medical ethics.

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Let me close with some examples. The word "abortion" and the technical operation it signifies functions in several symbolic systems in American life. Can you recreate the symbolic system most contradictory, even hostile, to your own in as convincing a way as one of its partisans?

What are the symbolic worlds within which the word "control" figures, in locutions like "behavior control"? From how many cultural traditions, and from how many social locutions (the educated, the uneducated, etc.), might people react differently to that locution? How do power relationships affect imagination?

When a family doesn't wish a relative to be told of the imminence of his death, what cultural images provide content for their understanding of "honesty," "compassion," "death"?

When parents desire a mongoloid child to die, rather than to approve of a simple operation that would save its life, what imaginative resources operate in their family culture that might allow further alternatives to be explored? and what resources are made available for helping such parents, through our present social imagination? (What is the shape and bias of our present social imagination? How did it get that way? How can it be altered?)

Some will no doubt believe that my theory gives too much power to the imagination. No more, I think, than human life itself does. Education of the imagination is the heart of the humanities, of ethics, and of the fundamental human experiences with which medicine is engaged. To be a free person is to have an imagination free to "cross over" into other standpoints.

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The main force shaping our symbolic world today is professionalism -- the expert in the white coat, his peers watching him, his techniques polished, his mind "tough", his knowledge "hard." If we wish to break out of that captivity, we must attack it in its stronghold: its grip over our imagination, over our sense of reality, and over our institutions. Breaking free from it, without destroying it, will be as difficult as breaking free from a religion.

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Author's note

Mark Zborowsky's People in Pain (Jossey-Bass, San Francisco) is a marvelous study of how "pain" is a quite different reality in the lives of Anglo Saxons, Jews, Italians, and the Irish.

Renee C. Fox illuminates many of the "symbolic worlds" in conflict in hospital situations in Experiment Perilous (Free Press, N.Y.; soon to be in Pennsylvania University Press paperback).

My own notions of "intelligent subjectivity," "sense of reality" and "story" are worked out in a philosophical-religious context rather than in a medical context, in the following sequence: Belief and Unbelief (Mentor Omega, 1967); The Experience of Nothingness (Harper Colophon, 1971); and Ascent of the Mountain, Flight of the Dove (Harper Paperbacks, 1971). The cultural and ethnic component of experience is further treated in The Rise of the Unmeltable Ethnics (Macmillan, 1972).

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"You can also say the professions are constructions or occupations or disciplines which apply to the liberal arts. If you want to learn the liberal arts, you better have great subject matter that will stretch them to their full capacities." - Scott Buchanan in Embers of World Conversations with Scott Buchanan, Ed. Harris Wofford, Jr., The Center for the Study of Democratic Institutions, Santa Barbara, Cal., p. 36.

INTRODUCTION TO THE SECOND INSTITUTE

Many of my reflections on the relationships of medicine and the humanities are printed in the Summary Paper of the Proceedings of the First Institute. These were made available before this conference and hence I will not read a formal paper today. I will simply gloss that text and comment on where I feel we are today in further exploring this matter.

In my Proceedings paper I suggested that one of the benefits that accrue to us from an exchange with humanists is that medicine can become a more fully examined profession. Dr. Novak has done just that in his opening paper. I am sure the insights and points of view he has presented are not necessarily shared by all of you; indeed, as he spoke some of you may have experienced the "psychic jolt" he described. I know that he has forced me to think, and to look again at some of my preconceptions. It is a very great service to us in medicine to have

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our profession inquired into by the humanist who can look at us as an object of inquiry and study. (Of course, the humanist will have to be prepared for a return look and therein lies a benefit for him. For the unexamined profession, or discipline, like the unexamined life is hardly worth pursuing.)

My purpose this afternoon is not to quibble, debate or rebut in what Professor Novak has said. Rather, I would like to try to focus on the purposes of this Second Institute by putting before your considerations (a) where I think we are today, (b) some of the questions that arose during the first session of the Institute last year, and (c) some of the newer questions I think we should address in the next couple of days.

Perhaps as you listened to Michael Novak's incisive observations you were saying "The good physician has always been a humanist; the good physician has always been aware of the point of view of his patient. I have always taken the patient's values into account. All you need is to be like me and there will be no problem." Each of us, of course, has his own configuration of ideas about who and what he is, and how good that is for his patients.

But despite the somewhat exalted self-image of our own humanism it is becoming painfully clear that among the many failures imputed to physicians, one of the most disturbing is the accusation that as a group we are insufficiently humane, humanistic, compassionate, or sensitive. This whole set of adjectives is used to describe a deficiency

in our behavior in dealing with some of the values pointed out by Professor Novak as intimate parts of the physician-patient transaction. Those of us who feel certain of our scientific competence defend ourselves against such imputations by falling back on that competence. Others, more pretentiously affect the image of the Renaissance man asserting that all we need to do is to resurrect that ancient model by revising our medical education, or our student selection process.

Yet when we really listen to our patients, those on whom we are attempting to perpetrate our self-image, there is no question that a certain dubiety has crept into the serene countenance of the physician as Renaissance man. Every sensitive physician who professes to be a "whole" physician in any sense recognizes instinctively that to fail in the human dimension of his profession is to fail in the only real basis for authenticity of that profession. The danger of hypocrisy is too obvious to be missed. The painful recognition of this fact is sufficient spur for a re-examination of our exalted self-image.

This then is the first good reason why at this point in time a greater exchange with humanists, is necessary. Collectively we are not behaving in a manner which is authentic for the physician who professes to treat the "whole" patient, or the "person behind the disease" -- those pious affirmations we preach and teach. Something in the affective component of the physician-patient transaction is obviously missing. At least, this is the judgment of those who look at us from the outside.

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The second important reason why a closer dialogue with the humanities is essential at this time arises out of the very progress of medicine which has given us capabilities heretofore unheard of, for controlling many facets of individual and communal human life. These capabilities are so potent that they must be used, and ordered, in a humane way. A whole series of new ethical and social questions have been raised which medicine as a profession needs to address. I need not enumerate these questions for an audience such as this. Professor Novak has mentioned a few, and there are many others.

Medicine has spent about a hundred years vigorously cultivating its contacts with the physical and biological sciences. The result has been unprecedented in the degree of technical capability modern medicine now possesses. In our eagerness to "humanize" medicine let us not erect an unnecessary dichotomy which demands either the abandonment of either the interface with science or the interface with the humanities. Medicine cannot meet its social responsibilities without both points of reference and inspiration.

Another interface which must also be sustained, is the one started some fifteen or twenty years when it was realized that the social and behavioral sciences have much to contribute to medicine. That effort has met with mixed and dubious success thus far, but we must not abandon it. Without minimizing the importance of what medicine has gained from the social and behavioral sciences, I feel that the exchange with the humanities now developing may prove even more important for the individual physician and for medicine as a profession.

Why has this relation with liberal studies become so necessary in medical and health professional education? After all, we now admit (for the most part) students to medical school who already possess a liberal education. We presume they have imbibed the liberal attitude of mind and to this we need only add professional education. The existing base of broad educational experience is further presumed to influence their personal lives, making them considerate and compassionate. As medical educators our task is to see to it that their professional education makes them competent. This filigree of presumptions has obscured our view of the actualities. This concentration of successive education experiences has not occurred. There are several reasons for the failure of the illusion.

First, as Professor Novak pointed out, the state of the humanities in our universities today is such that they themselves have become technical specialities. They have made a considerable fetish of being value-free and of assuming the "objective" stance of the sciences. While this may be of some importance for the development of the humanities qua humanities, it is lethal to the kind of contribution the humanities can make to the critical examination of other professions.

Second, by and large the humanities are still taught by the deductive approach, by proceeding from abstract to concrete and from theory to practice. Literary values, for instance, are too often taught by taking courses in "literature." Little of current teaching is rooted

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in the phenomenological or in the critical human problems of everyday life -- each of which involves values, truth, and the esthetic dimensions of existence. Especially deleterious is the insistence that liberal studies must precede professional studies in all instances and that their application to the profession must come "later."

Third, there has been too much of an attitude of "try it - you'll like it," "it's good for you." "You must take the humanities to be educated." In their effort to expose everyone to a liberal education the humanists have quenched the sparks of interest even in the susceptibles. Some people should be allowed to prepare for a role in life without insisting on the humanities as an obstacle course to be run before they can get at their major interest. Forced medication with the humanities may induce a hypersensitivity reaction which will forever prohibit effective imbibition of what the humanities have to give.

Finally, too many humanists still perpetrate the nineteenth-century notion of the intellectual life. This approach to liberal education is sophisticated but eminently aristocratic and elitist. It is a view quite inconsistent with the requirements and expectations of the majority of students attending universities in a democratic society dedicated to mass education.

The interrelationships with medicine are not going to rescue the humanities, and I am not prescribing a salvation theme for the humanities. I do want to emphasize, however, that a "liberal" education acquired prior to medical school does not excuse us from concern about

the medical students' grounding in the area of human values or his capacity to consider such qusstions as he encounters them in his professional education. Some of our colleagues say that humanistic studies are not the medical school's business, or that we should simply insist upon more liberal studies prior to entry into medical school. It is this stance which we have questioned in the first Institute and we shall question again in this Second Institute.

Nor is medical school the only or final point of contact with humanistic studies. To be effective, this contact may occur at any point in the life of the physician. It may be more appropriate and meaningful for some persons at one point than at another. To present the humanities as a set of prior obstacles to be overcome before one can get on with the real business of medicine, is to induce repudiation and revulsion, especially for the goal-oriented students who see only service to people as the end point of medicine. If it is useful to develop the imagination in the terms Professor Novak has suggested, must we do so only before medical school? Surely this aim can be achieved before, during, and for some after formal medical education.

Whenever the introductory point may be, we are missing grievously the opportunity for interjecting the humanities realistically and relevantly into continuing education. In recent experiences with practicing physicians who were asked to choose subjects for continuing education, the subjects of social and individual ethics were as often sought as technical and professional subject matter.

The specific issues of concern to these practitioners included not only the newer questions in medical ethics like abortion, euthanasia, death and dying, but also the broader issues of decision making regarding use of new technology, the possibility of a new and expanded profession ethics and the education of the physician as a person in the substance of history, art, philosophy as means for increasing his own satisfaction with life. Educators are not yet responding to this challenged opportunity.

Can academicians be responsive enough to entertain a pluralistic approach to bringing humanities into medical education? On this score I do not quite see the separation that Professor Novak made between professional education and education of the imagination. I believe they can be intermingled if we are willing to offer several different modes and times of engagement with liberal studies. For example, students who are clearly uninterested in the humanities when they enter medical school should be allowed to concentrate on medical studies until they develop humanistic interests. We must also simply accept the fact that some never will develop such interests. Others, though, will want only to postpone an investigation of the relation between medicine and the humanities, until they overcome their anxieties about getting into medical school or succeeding in medical studies.

Still other students will arrive at medical school with some prior exposure to humanistic studies and a continuing interest in them. They should have the opportunity to deepen this knowledge within the context

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of their medical education. All physicians, after they have received their medical degrees and even after they have begun or completed additional training, should be provided with continuing opportunities to return to repeated considerations of human-value issues.

I have tried to develop two major points so far. First, the nature of the humanities and the way they are taught today makes them unpalatable or ineffective for many goal-oriented students so that simply turning to the humanities as they are taught and practiced now will be insufficient for our needs. Secondly, we need to expand the variety of approaches and the times at which a liberal education can be interjected successfully into the life and consciousness of a student or practitioner of medicine.

Next, I wish to warn against a recurrent tendency in conferences dedicated to medicine and the humanities. I refer to the irrepressible urge to reincarnate the Renaissance man in the person of every physician. Let us be wary of setting the goal of medical education to make <u>every</u> physician fully competent, as well as compassionate and, in addition, literate and educated. These three levels of professional and personal existence constitute a desirable and attractive Platonic ideal. But, the ideal can be approached only asymptotically. The depth to which each physician cultivates these three realms is highly variable and dependent upon his intellectual gifts, his personal maturation and his own cultural predilections. No curricular design, aimed at inculcating all of this in every student can be successful. The price we pay for

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our failure is measured in wasted hours, forced feeding of liberal studies soon forgotten and a negative response to future encounters with such studies.

The goal must be more realistic and more attuned to the functions the physician may choose to perform in society. Some hierarchy must be established among the three realms of a physician's existence-competence, considerateness and conversance.

Competence is indispensable and can be compromised the least. Without it the physician's very profession is inauthentic, his acts are a menace and his whole life an hypocrisy. Competence cannot be other than the base upon which the other dimensions are built.

Some measure of considerateness for the person of the patient must be added to competence. Without it there is, at the least, an unsatisfying though safe encounter between physician and patient. At worst, the physician without consideration may use his competence for selfish interests or even against the patient. When we speak of "consideration" in these terms we subsume the multiple connotations of somewhat more pretentious terms like "compassion," "Humanitarianism" and "humanism."

In more ordinary terms still, we must recognize that much criticism today is levelled at physicians for failure to observe some of the simpler features common to any human relationship such as courtesy, respect for the belief and intelligence of the patient and understanding of his value system. It would be illusory to think that exposure

to the cognitive demands of the humanities would make the physician considerate in this sense. I hope in this conference, that the participants will examine more closely, this distinction between the cognitive and affective aspects of "humanism" as well as the educational modes proper to each. Only in this way can we avoid the over-inflation of our expectations for the humanities in medicine and look more specifically at how to modify the physician's behavior in the personal encounter with his patients.

If the majority of physicians can be educated to be competent and considerate, we will have done much to make medicine a more responsive social and personal instrument. Hopefully, a significant number of physicians can also become "conversant" - that is capable of seeing the connections between medicine and the culture within which it resides. We would be unwise to aim at a universal literacy among physicians or the capacity to converse with patients about literature, the arts or philosophy. This would be again to pursue the myth of the Renaissance man. But surely some perception of the value systems held by our patients would appear essential for even the most rudimentary approach to understanding the patient and communicating with him. The humanities will never make every physician eloquent, critical of ideas, and literate. But they might sensitize physicians to varying degrees of comprehension and enjoyment of those studies that are specifically humane and foreign to other species - the arts of expressing thought and imagination.

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In short, as our discussions deepen during this conference, I am suggesting that we concentrate on a few clearly defined objectives, freed of pretension and matched to the actual demands of patient care and eschew utopian schemes for universalizing liberal education in its elite sense for all medical men - a task no more achievable with this profession than with lawyers, teachers or even professors of the humanities.

Another reality to which we did not pay sufficient attention in the first Institute is the need for similar exposure to the humanities in the education of the health professions other than medicine. The education of physicians fortunately is becoming less isolated from the education of their fellow health professionals. We cannot prescribe for the other health professions in this Institute. We have chosen to concentrate on the needs of medicine as a first step. Hopefully, however, we will remember that interprofessional and interdisciplinary learning is an emergent necessity if we are to enhance the future cooperative efforts of the professions in patient care.

The humanities, when integrated into professional studies, offer effective opportunities for shared educational experiences for all health professionals. Four years of formal pre-medical education usually give medical students the edge in scientific studies. Their sophistication and perceptions in the humanities are not demonstrably greater than those of students in other schools of the health sciences centers. The issues of values, ethics and esthetics in medicine can be appreciated by all students in the context of the patients or clinical contexts they

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confront daily. Indeed, I believe that seminars in the humanities as applied to clinical problems will prove the most effective means for combined educational experiences, exceeded in value only by actual practice in interdisciplinary patient care teams.

Another pitfall to avoid is the over-adulation of the humanities. It is too easy to write a prescription of "requirements" which every student must "take" or "pass." We should recognize the curriculum for what it is, a tool for engagement of the mind and person of the student. Recognizing this, will help us accept the fact that some students will react negatively, the majority with modest interest and a few with enthusiasm. Especially in the humanities we must allow a wide choice of topics and restrain the standard pedagogical demand for a formal course-work. Some students simply do not see any value in the questions with which humanities deal. We can only help this group understand why they are not interested. For some of them the worth of such inquiries will come later - and for some perhaps never.

We should, however, create opportunities in the clinical setting of daily and grand rounds to discuss humanistic questions as rigorously as we now discuss scientific questions in the care of the patient. In this way, every student will have a chance to make up his own mind about the relevance of the issues. He can see at least that they do concern his teachers and professional colleagues. This may heighten his interest, or confirm him, in his rejection. But at least the school would have taken its stance on the importance of the human dimensions of illness as an everyday concern for all of us.

This leads me to underscore what was emphasized in the first Institute - namely that the only really effective teaching of humanities for students in the health professions is that which occurs in the concrete clinical situation. Such teaching arises out of the problems faced by patients and the students themselves as they try to help their patients. I will not repeat the comments I made in the first Institute on the difficulties for humanists in working in this context but they are not inconsiderable.

All of us involved in planning the first Institute and this one hope you will accept as given, the need for an exchange between medicine and the humanities - and specifically for this session, we are hoping to move to a discussion of the concrete features of such an exchange specifically as an educational experience in medicine. We are ready, I believe, to look at such specific questions as when the humanities should be taught, what should be taught, by whom to whom, and for what purposes? There is mounting interest in this matter among medical and university educators and in the educated public - all of whom sense the unique position of medicine - which is evolving as a form of technology and science on the one hand and as a means for making human existence more humane on the other. Can there be a better subject matter to stretch the humanities to their full capacity as Buchanan's quote at the heading of this discussion intimates?

SUMMARY OF GROUP DISCUSSIONS

Lorraine L. Hunt, Ph.D.
Project Director

FOREWORD

The participants in the second session of the Institute on Human Values in Medicine were asked to devote their small-group meetings to exploration of the preliminary issues that must be clarified before any new teaching program is undertaken. These basic matters concern what is to be taught, why, how, and by whom. These questions were posed to participants under the rubrics of rationale, process and context:

THE RATIONALE: *Why human value studies in medical education?*

- What kind of rationale would be viable in your institution?
- What actual changes in the institution and its educational process would you like to see accomplished?
- What would be your priorities among these changes?

THE PROCESS: *How are matters concerning human values best taught and learned in medical education?*

- At what places and times in the medical education experience would you seek to introduce these perspectives?
- In what forms (conceptual data, disciplines, and methods) would you feel values could be best introduced?
- In what ways can you measure the effect of such a program?

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THE CONTEXT: *What are the resources and what are the impediments both inside and outside the institution?*

What would be the major impediments to the introduction of these values in your institution?

How could you best deal with these?

What are the resources, leverages, and reinforcements within the institution that could assist in accomplishing these goals?

What extramural resources would be helpful or necessary?

The following pages present in sharply condensed form the results of all groups' deliberations over the issues raised by the questions just listed. The individuals who served as recorders for each group contributed the reports from which this summary has been prepared. The group chairmen assisted the recorders in addition to leading the small-group discussions. These duties imposed extra burdens upon these individuals which they discharged with grace as well as competence. With great appreciation the Institute acknowledges its indebtedness to:

Chairmen	Recorders
Richard C. Reynolds	Marjorie A. Boeck
Robert E. Carter	Roger J. Bulger
Robert Graham	Robert P. Hudson
T. Hale Ham	K. Danner Clouser
George T. Harrell	Sam A. Banks
Calvin H. Plimpton	Chester R. Burns
Robert D. Sparks	E. A. Vastyan
Joe P. Tupin	Richard R. Willey
George A. Wolf, Jr.	Gerard J. Hunt

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The terse lists on the next few pages have important complements elsewhere in this report and in the Proceedings of the First Session. Additional comments on rationale, process, and context are offered in the self-descriptive reports of on-going human values programs in eleven medical schools. These reports were distributed as background material prior to the second session, and are reprinted here in the second section of this volume.

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THE RATIONALE

Why human value studies in medical education?

Medical education is already hard pressed by competing demands for curriculum time and all resources that support teaching. Formal studies in the area of human values will not be given a chance to develop unless the proponents can advance a clear rationale that is viable at their institution. The skills and knowledge that can be imparted by humanistic studies must be specifically identified and forcefully articulated.

FOCUS ON THE MEDICAL STUDENT AND HIS LEARNING

Humanistic studies can be directed toward helping the medical student develop attributes such as these:

Perceptual and communications skills necessary for understanding the self, the patient, and the social setting in which health care occurs.

Understanding of and respect for cultural characteristics and differences.

Tolerance for ambiguity.

Broadened perspectives on the role of the physician.

Understanding of the threat to human values that is implicit in the technology of medicine.

Personal flexibility and adaptability to change.

Qualities of a personal counselor, including ability to help patients learn principles of conduct and decision-making that are appropriate to illness and other life situations.

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FOCUS ON THE PHYSICIAN AND HIS TASKS

The humanistic skills and insights learned early in medical education (see above) can subsequently enhance the physician's performance of his basic tasks:

Eliciting relevant information from the patient.

Identifying certain problems in the patient.

Formulating a plan for treatment.

Evaluating what he (the physician) has done.

Developing (through repetition and over time) competence and responsibility in medical problem-solving, including the social and cultural components.

FOCUS ON THE PHYSICIAN AND HIS ATTITUDES AND FEELINGS

Humanistic studies have natural relevance to the human problems the physician must face while dealing simultaneously with his own feelings and attitudes. Knowledge of the humanities can be personally helpful to the physician who is confronted by his own humanity in situations involving:

Disease and pain - dying and death: Although the physician is expected to handle patients' and families' feelings about these matters, often he is left alone and unaided with his own feelings.

Error: The physician acutely fears being wrong, and has great difficulty accepting his professional limitations and personal finitude.

Criticism: The physician needs help in developing perspectives that will enable him to profit from criticism and questioning. He needs encouragement to cultivate self-reflectiveness side by side with professional distance.

THE PROCESS

How are matters concerning human values best taught and learned in medical education?

Different places and points in time in the course of medical education both permit and require different approaches, mechanisms, and tactics.

WITHIN THE MEDICAL SCHOOL YEARS

Weave human values into a basic course devoted to the study of normal man, and aimed at developing understanding of human growth and development, including personality.

Consider epidemiology, ecology, and their effects in the development of illness.

Schedule active participation in the medical science courses by a humanist who will speak to the relevant issues when and where they arise in their natural context (e.g., sessions on death in anatomy courses; discussion of values questions during instruction in interviewing and history-taking).

Use literature, history, philosophy to explicate and teach human values. Conduct didactic classes to give foundation and conceptual framework--but they must be directed to the needs of physicians-in-training, not humanists-in-training.

Develop special electives in humanities for in-depth work. This should include studies keyed to medical problems. Humanistic studies can be developed either by structural (departmental) or experiential and unstructured modes.

Develop programmed self-instruction that uses humanistic resources.

Design evaluation systems for both faculty and students that include humanistic perspectives.

Use organizational development/educational theory to change teaching methods.

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WITHIN POST-GRADUATE EDUCATION

Reinforce at the post-graduate (or senior) level education about ethical issues and responsibility.

Encourage further understanding of human behavior, especially as approached by the behavioral sciences and psychiatry.

Urge interdisciplinary scholarship and research. For example, the insights of literature should be applied to the study of human sexuality.

Use resources from social studies to deal with issues of racism, sexism, etc. as confronted by medical professionals.

Make formal courses available to meet known interests in areas such as contemporary social problems of medicine.

Arrange panel presentations by active practitioners who regularly face problems of euthanasia, abortion, et. al.

WITHIN THE CLINICAL SETTING

Tie human values into the clinical setting as a factor that has impact on the health/disease experience, and on the self, family, and community.

Use the practical experience of the core clerkship to illustrate how human needs are dealt with.

Encourage interdisciplinary teaching within clinical rounds (both medicine and surgery), grand rounds, and staff conferences.

Involve the humanist in the routines of outpatient departments and in "situational" teaching, as human value problems arise on the wards.

Encourage ethics-centered CPC's.

THROUGH ACTIVITIES WITHIN THE INSTITUTIONAL COMMUNITY

(medical school + teaching hospital + the administration of both)

Hold special conferences of one, two, or three days devoted to special issues such as human experimentation, delivery of health care, etc.

Sponsor symposia on critical decisions facing medicine.

Make available within the institutional community adequate quantities of humanistic resources (books, appropriate films, journals, etc.)

Develop a comprehensive counseling system for students, interns, residents, and all members of the institutional community.

Work with the faculty to improve role models for students.

State explicitly and repeatedly that a humanistic orientation is a recognized, desired, and altogether legitimate institutional value.

Hold workshops and sponsor film series on humanistic issues.

THROUGH ENGAGEMENTS WITH THE OUTSIDE COMMUNITY

Consciously seek understanding of community resources and community medicine.

Use and cooperate with social action groups in the medical field.

Develop ways to educate communities to cope with crises such as death, natural disasters, and widespread health problems (alcoholism, drug abuse, mental illness).

Involve patients in evaluation systems.

Invite citizens to offer their views and participate in decisions about deployment of kidney machines, donation of organs, human experimentation, etc.

Place students in the offices of local private physicians and community clinics.

Evaluation

Evaluation of a human values program requires not only examination of the program's accomplishments, but also examination of the institution's reciprocal response.

Creating an opportunity for the development of a meaningful human values program involves:

Admissions: Admissions policies must reflect the institution's explicit commitment to human values as an educational goal; thus candidates for admission must be required to share this commitment.

Faculty Recruitment and Advancement: To be hired, promoted, and advanced professionally, faculty members must also demonstrate their personal commitment to education in human values as an institutional objective.

Measuring Instruments: Evaluative instruments must be developed and employed in a serious, sustained effort to make value-centered education consistent and concrete. Specific behavioral, attitudinal, and informational objectives of each part of the program must be stated at the beginning and tested at the end.

Time: No educational innovation can be evaluated accurately or fairly during its developmental phase. Human values programs must be given adequate time to prove themselves--perhaps a minimum of ten years.

Support from Accreditation Committees: Meaningful support can come from accreditation committees. Their examination of a medical school's total curriculum could include inquiry into the institution's plans for or progress in developing a formal human values program.

THE CONTEXT	What are the resources and what are the impediments both inside and outside the institution?	*Any new program represents a threat to the limited resources of time and money in the medical school. The administration's and the faculty's reaction to this threat is commonly expressed through resistance to change.*

IMPEDIMENTS TO THE INTRODUCTION OF HUMAN VALUES PROGRAMS	FACTORS SUPPORTIVE OF THE INTRODUCTION OF HUMAN VALUES PROGRAMS
Competition for time in the curriculum, coupled with the view that humanistic studies belong in premedical education.	The premedical years' focus on scientific preparation and their separation from the clinical setting make them an inappropriate time for perceiving the relevance of humanistic studies to medicine.
Competition for funds.	New sources of funds for human values programs are becoming available from private foundations and federal agencies that support the teaching activities of medical schools.
Lack of appropriate formal study materials.	Bibliographies, course outlines, recommended reading lists, and directories of films and videotapes are readily available from experienced teachers.
Lack of appropriate faculty.	A cadre of interested humanists and physicians can be identified (the "new breed"). Faculty development programs can be designed to accelerate the humanist-teacher's adaptation to the medical setting, and the physician-teacher's assimilation of humanistic knowledge.
Administrative and personal difficulties caused by taking humanists into the medical setting.	Eleven medical schools have achieved successful resolution of these problems. (See section two of this volume.)

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IMPEDIMENTS TO THE INTRODUCTION OF HUMAN VALUES PROGRAMS (continued)

Pressure for more study of science as the momentum of technical advance propels medicine into super-science.

Resentment of non-physicians' involvement in medical matters ("professionalism").

Process problems generated by some of the forms chosen for teaching human values in the medical school.

Lectures: hard to schedule around clinical clerkships.

Faculty Conferences: members are resistant - have too many other demands on their time.

Interdisciplinary Teaching (involving faculty from outside as well as inside the medical school): consensus on objectives difficult to obtain - leadership difficult to assign - everybody too busy for meaningful joint curriculum planning.

Videotapes and Films: expensive - require technical staff - raise problems of production, staging, and viewing.

Retreats: expensive - effects tend to be short-lived.

FACTORS SUPPORTIVE OF THE INTRODUCTION OF HUMAN VALUES PROGRAMS (continued)

Society, government, and individuals feel great anxiety and threat as they anticipate increasingly dehumanizing developments in medicine. They seek a counter-balancing emphasis on human values.

Society demands a share in decision-making about medical education and the cost, quality, and delivery of health care.

Genuine institutional commitment to teaching human values has resulted in various solutions to these difficulties at eleven medical schools. (See section two of this volume.)

MEDICINE AND HUMANISM: EVOLUTION IN PROCESS

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I realized, when I began to prepare this concluding address, that I was starting with a great advantage, namely, the knowledge that I am speaking to a sympathetic audience. This, even though I speak as an Englishman in the heart of Williamsburg! So far as I can judge, the last recorded public exploit of my compatriots, before you won your independence from us, was to get caught red-handed in the middle of the night stealing the citizens' gunpowder from the building just across the road. That was nearly two hundred years ago. The Irish, perhaps, would never have either forgotten or forgiven, but I know that you Americans have forgiven, at least, and so I am relieved of anxiety - on that score at any rate.

Much more, I know you to be sympathetic to me as summarist, not only because you know the difficulties of the task as well as I, but primarily because I have realized that in many fundamental questions relating to this conference, your thoughts and mine are very congruent. They are not identical, certainly, and in many areas minor differences have cropped up between all of us during these last three days. That is inevitable in an assembly of seventy intelligent and articulate people struggling with very complex problems. Since our small study-groups have consisted of only seven or eight members each, everyone has

spoken his mind; there seem to have been no backsliders, who have sat quietly in the corner and not said what they wanted to say. As the old Latin expression says, "Quot homines, tot sententiae" ("There are as many opinions as there are people"). We have seventy people here with seventy different life experiences behind them, and therefore with seventy different attitudes and opinions to bring to this discussion. So, let us agree that there has been a certain amount of disagreement on some matters, mostly minor, however, on the major issues we have found, during these last few days, that we think very much alike. I do not expect, therefore, that anything I shall say today, or anything you may say, will cause any of our hackles really to rise. Basically we are in agreement; though, for the sake of interest, perhaps I shall try to be a little provocative in the next half hour.

What we are agreed on is that we do want to promote the incorporation -- or perhaps one should say, the reincorporation -- of human values into the study and practice of medicine. Now, as one of my academic forebears in Cambridge, England, once wrote, "There is only one argument in favor of doing something, and that is, that it is the right thing to do. All other arguments are arguments against." In going back to our homesteads, to our various universities and medical schools, we have to think out ways of defeating negative arguments against our proposals as and when they are advanced, as they certainly will be in our respective schools.

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At the leaders' meeting before the conference proper began, I said that as summarist for this conference, I had come here with a tabula rasa -- with a blank sheet on which to record impressions of the meeting. I do assure you that my speech today was not composed last week, nor even on the long flight from Los Angeles (that haven of peace, specially reserved for reading, thinking, sleeping, or writing). In fact, I did not start this manuscript until after I had met last night for an hour and a half with the nine recorders of the working groups. After we had discussed together some major issues arising out of the group discussions, I went off and read all of the recorders' written reports: 58 pages of them, amounting to some 16,000 words.

I should like at this time to express a word of thanks and congratulation to the recorders and chairmen of the study groups. These working sessions have formed very valuable base material for our development. The reports will be summarized by Lorraine Hunt and included in the Proceedings of this session.

Of course, we all benefitted enormously, at the outset, from that luminous, illuminating address of Michael Novak, with his theme of "Liberation of Imagination" as the true goal of humanistic studies. One might say, incidentally, that great scientific advances, too, have only ever been made through someone's liberated imagination being able to enter into a larger paradigm, into a new hypothesis, capable of embracing more of the phenomena, in his specific field of inquiry, than were ever before integrated into a meaningful whole. I think, therefore,

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that Michael Novak's view about liberating the imagination is very relevant not only to humanistic studies but also to scientific studies of high order.

We have also benefitted, from the beginning of this conference, from Ed Pellegrino's wise and judicious assessment of the problem we face in trying to reintroduce human values into the study of medicine. If Ed will excuse the inversion of the metaphor (and its follow-up), it seemed to me that he was saying, in a nutshell, that our problem is how to put the big humanistic baby back into the bathtub without displacing and losing the marvellous, soapy scientific bathwater that has been collected and guarded so assiduously over the years.

Let us be clear: before Flexner some sixty years ago, that is before the scientific revolution began to exert its great effects in medicine, the bedside manner (or bathside manner, in the metaphor I am pursuing) might have been gracious and humanistic enough to satisfy any number of criteria of good manners. But there is no doubt about it: the baby in those days really was pretty dirty. It smelled, and had a habit of dying of those intercurrent infections which our modern, scientific bathwater "washes clean away". So let's not throw out the bactericidal bathwater for the sake of the baby, no matter how cherubic it may initially look. What I am trying to say is that in this science-humanities debate, we really must make sure that we come up with a both/and conclusion, and not in any sense with an either/or.

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One reason why we have been able to reach a large measure of agreement on the need to reintegrate medicine and the humanities, is that we are living now in a new phase of the history of civilization. That sounds like a big airy phrase which might have been said by any rhetorician at almost any time in history. But I happen to think that today it is true. If we just look around, and think, and listen, everywhere today we hear the cry for multidisciplinary, interdisciplinary, supradisciplinary studies. Most academics, scholarly (and not so scholarly) colleagues entrenched in the universities, merely mouth these phrases, but then proceed to do sweet nothing about them. And yet, these same academics are being actually forced to mouth them at this point in tim. because of social forces which are quite beyond their control.

Those of us who not only talk about interdisciplinary and supradisciplinary studies, but actually try to do something about the issues involved (as in this conference) are, in fact, moving with the evolutionary tide, instead of (like King Canute) trying to command the tide to halt. Canute, of course, was actually demonstrating a reality to his stupid advisors and interlocutors. We too might try to demonstrate the same truth to colleagues back home, in the fastnesses of departments of surgery or biochemistry, or wherever the opposition to humanities in medicine happens to be in our particular institution. In other words, we have to point out that the tide is on the move, and that it is stupid to try to halt it.

The plain fact is that the age of the isolated specialist is drawing to an end. More particularly, the age of a medical power structure based on the empire-building of non-cooperating specialists is drawing to an end. As in the larger fields of human endeavor, we in medicine simply must learn how to cooperate with one another, or we shall all perish. The public will not stand for much longer the kind of ultra-specialist medicine which for two generations has been all in vogue. This, to my mind, is what lies behind the remarkable recent volte-face in portrayals of medical practitioners on TV and movie screens. The same social forces lie behind the extraordinary movement evidenced in concern for ecology, or in the powerful anti-war movement amongst the young. As one international observer put it to me a couple years ago, "In the thinking of young people today, the whole notion of 'foreign politics' as distinct from 'domestic politics' is literally meaningless, in a world which they see increasingly as a small spaceship earth with limited resources."

To me, the fascination of the current phase lies in appreciation of the fact that we must not repudiate the past, as some people are advocating, but rather we must build upon it and go beyond it. We must not destroy the technology on which we currently so largely depend, but we must harness that technology to serve true human values instead of letting it always serve the interest merely of individual or group practitioners. We need to use all our resources, it seems to me, including those of the most advanced medical technologies. But we must

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use them in harmony with all the other resources of mankind, including all that the humanities have achieved during a period of quite a few thousand years. In other words, our endeavors to reintroduce human values into the teaching and practice of medicine ought to threaten nobody, except, perhaps, those power-hungry chairmen of departments, who will find that, with true human values as a prime consideration, they can no longer get away with their insensitive power games based on the nineteenth-century concept of the "survival of the fittest".

Why do I feel so sure that the time is now, that the time is ripe? Mainly, I think, I feel this way because our students are actually demanding it -- and mostly for very good reasons. Many of them are truly concerned with the delivery of health care in the broadest sense. Some of them seem to feel an extraordinary sensitivity to the needs of the sick and the poor, the disadvantaged, and the outcast. They spend long hours in free service in social and community clinics, and that requires a considerable degree of dedication.

Of course, the motives of these young people are often mixed and conflicted. Sometimes they are simply opting out of the hard intellectual work, and other kinds of devotion, which are required in the technical specialties in medicine. If we find that this is the case, then it seems to me it is up to us to ensure that they at least come to realize the rather suspect nature of their own motivations and activities. We must make them see, for instance, that for someone

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with renal failure, with a coronary thrombosis, or with a brain tumor, effective patient care can only come through the acquisition and the practice of skills and knowledge that take far greater efforts and many more years to acquire, than they sometimes seem prepared to give. Again, we must insist on both/and rather than either/or.

It may well turn out to be different groups of people who will carry on these different tasks. I fully agree with Ed Pellegrino that the day of the Renaissance man is over (although he himself seems sometimes to deny in action what his words proclaim). It is team work that we need in medicine, as in all social and political life. What the humanities can give us is precisely the necessary empathy to recognize that someone who is doing something way outside our own comprehension, outside our own particular interests or abilities, is someone we ought to be able to admire and be grateful for, rather than seeing him as an alien who represents some kind of threat to us.

Society, then, is demanding changes in our system of medical education and medical care. Perhaps what we really need is a new kind of Flexner. He might, perhaps, come from the field of education, as Flexner himself did. Flexner was no medical Dean: he came from outside the medical field, and yet he did a most remarkable job of analyzing the system of medical education as he found it in the early years of this century. The new Flexner may come from education or sociology or economics, but he will have to be someone who will take a long hard look at medicine as a whole and then expose its weaknesses, as Flexner did. In

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his time Flexner saw, quite rightly, that medical schools needed a big shakeup. They needed a tightening up of intellectual standards all around; in particular, they needed a stricter emphasis on the scientific technique instead of the technique of bedside platitudes and mystery potions. Today, perhaps we have gone too far in that direction; and perhaps we at this conference recognize this shortcoming better than some of our colleagues in the medical schools.

This conference has many suggestions to make, as you will see when you receive the reports of the study groups to which you have contributed. If we can convince our colleagues back home by skill and diplomacy, perhaps we shall avoid the distress that another Flexner-type investigation or inquisition would inevitably produce. Perhaps we might accomplish our goal by an evolutionary process rather than by the kind of revolutionary process that happened some fifty years ago, and in which many people must have suffered a great deal.

What is it we are suggesting? In the group reports you will find that every phase of medical education is identified by one group or another (or sometimes by two or three groups), as the most significant for the necessary inculcation of human values -- of humanistic or liberal intelligence, to use Michael Novak's phrase again. For example, our medical admissions committees must look at their prerequisites. For too long now we have concentrated only on the reductionist techniques of the basic sciences: physics, chemistry, biology, and mathematics. Some of the groups are suggesting that we must begin to give emphasis to selecting applicants on bases other than their studies in traditional physical

and biological science. It may be that we are turning away many, many candidates who would do extraordinary well in medicine, and would bring with them, as well as native intelligence, precisely those humanistic values we are so concerned to promote.

If we insist only on the reductionist techniques of the basic sciences, then we are insisting on an attitude of mind where fundamentally every phenomenon that is observed is to be explained in terms of a reduction to a simpler phenomenon, as in physiology reduced to biochemistry, and biochemistry to chemistry, and chemistry itself down to physics. With this reductionist technique one ends up finally and inevitably with atoms and the void. The problem of "the meaning of meaning" is surely the biggest problem of the 20th century. As we all know, there is a certain randomness about atomic behavior, so that in traditional "science" one ends up with a big question mark. This is as true of human beings, if one adopts that reductionist line, as it is of any other manifestation of nature. Do you have any meaning or significance? Do I? Fearful issues, and yet this is how we have been schooling our pre-medical students up until now. Thus you will see recommended, in some group reports, that the emphasis ought to be on the inculcation of human values before students even start in medical school.

But then, others say the first two years of medicine are really the crucial time, when a student meets death, probably for the first time. He meets it in the dissecting room in the anatomy department,

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where he starts picking a corpse to pieces, again following the standard scientific, reductionist, philosophy of analysis. This, some of us have said, is the time to start him thinking about the human significance of death and dying -- and of birth and living, by contrast.

But then, say others, the clinical case conference, or the clinical-pathological conference, is the right time to insist on reflections on what it is to be human, what it is to have rights and duties. But again, surely it is with internship and residency that the budding doctor actually assumes, and begins to feel the burden of, his responsibility for other people's lives and deaths? That, then, is when he needs the humanistic experience, say some. And then, some of our groups consider that it is the faculty member, the practicing clinician, who needs seminars and consultations on all aspects of humanity. Then he will teach this point of view to the students by example, as the great Osler always did. Maybe we need exposure to the humanities all of the time. That is what seems to emerge from my analysis of the working groups.

I would point out to you that more than one group suggested that the introduction into clinical practice of some kind of problem-oriented medical record might be the most direct way to develop consideration of human values in every individual case. This is not to say that the Weed method (as it is generally understood) is the only way to achieve this end. Virtually every school represented here has at least one department which is already practicing the Weed method, the "problem-oriented patient record," as the most effective way of analyzing a patient in the round, so to speak. It might be that with some modification of that technique,

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we could get across an inevitable concern for human values on the part of every student, every intern, every resident, every faculty member who is involved in the treatment of a given patient.

In two other groups reference was made to "medicine-society conferences", similar to the clinical-pathological conferences which are fundamental in all medical schools. The medicine-society conferences spoken of here have been a great success at the University of Virginia, where they have been run by Tom Hunter and Joseph Fletcher. They consist of a case presentation and an analysis of the patient's clinical and social condition, together with an ethical consideration that involves multidisciplinary argumentation on all sides. Such conferences have been drawing enormous audiences and a great deal of interest. Although they can be viewed as a once-a-month shot-in-the-arm, so to speak, it may be that through such techniques it is possible to get students, interns, and faculty interested in understanding more about human, as distinct from purely technological values in their respective areas of responsibility.

To my mind, the plethora of suggestions and recommendations about timing and methods, that have come out of our nine discussion groups, are wholly welcome and wholly to be expected. As I suggested earlier, we are now at a stage of great change in civilization, and, as has happened at all stages of rapid growth in civilization in the past, we are in a period of imaginative exploration. Intellectual exploring is the human activity par excellence: it represents, at a human level,

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the exploratory activity of all biological organisms. This is an activity that shows itself most markedly at times of vigorous biological evolution. "Groping" is the word that has been used to express this particular phase in the history of evolving systems. At the stage of vigorous growth, there is active groping, active "looking" (whether conscious or not) for solutions.

Depending on the circumstances of location, personnel, money, and many other things, we will find, in our different medical schools, that one possible avenue in this groping, exploratory process will offer a greater chance of success than another. Then take it. Take that avenue, or try the two or three best ones, as they seem most appropriate in your local circumstances. After all, the only criterion of evolutionary success is survival, or success itself. In our strategies in these matters, we must be, as the Bible suggests, "as wise as serpents, but as gentle as doves."

We shall meet opposition from entrenched faculty. They will defend themselves in many different ways, but most commonly, perhaps, by trying to brush off the unwelcome by pretending it has no value. This opposition will at times be considerable. The academic life is by its very nature conservative and settled, and we must not be put off by thick-skinned dinosaurs, even if they happen to be Nobel Laureates, whether in Science or the Humanities.

At the beginning of this address, I gave a quotation about there being only one argument in favor of doing something: that it is the right thing to do. That is a phrase (quoted from memory) from a small

gem of a book entitled Microcosmographia Academica, which consists of advice to a young man about to enter the murky world of academic politics. It was written about 1910 by F. M. Cornford, a very astute professor of ancient history and philosophy in Cambridge. The book is still in print; it is now in about the fifteenth edition, and Bowes and Bowes, one of the local bookshops in Cambridge, go on reprinting it every few years.

This little book includes thumb-nail sketches of virtually all the academic types and situations one has ever met. A cardinal point for Cornford, in his thoughts on the game of academic politics, was the prior assumption that almost everybody in the university was what he called either a Liberal-Conservative or a Conservative-Liberal. The distinctions between these two great parties are subtle indeed, and "crossing over" from one party to the other is not at all uncommon. Although they are so alike on every issue, yet of course, like any members of political parties, they are always loud in their denunciations of the other's proposals.

According to Cornford, this is really an academic smoke-screen, designed to ensure that the other, much rarer, type never get a chance of a hearing at all. This much rarer type is the one Cornford calls "The Young Man in a Hurry." The young man in a hurry can be any age; he need not actually be young to be called, by both Liberal-Conservatives and Conservative-Liberals, a "young man in a hurry," that is, a

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"radical". We, as a group at this conference, remind me very much of Cornford's young men in a hurry, because they are the ones who actually want to get things done and to initiate change (of all things!) in the settled routine so characteristic of academia.

When Cornford wrote his book, some sixty years ago, nearly all the young men in a hurry, apart from himself, were the scientists, those men who lived "in caves, somewhere beyond Downing Street". (You have to know something of the place to appreciate the disdain, in that expression, in the way scientists were regarded at that time by humanists in Cambridge!) But now, it seems, in 1972, the tables are turned. No longer are the humanists -- the linguists, philosophers, theologians, historians -- the ones who occupy all the places of wealth and power and privilege of academia. At the start of the century, the string-and-sealing-wax scientists (as they were in those days) were knocking at their doors with the English equivalent of "Brother, can you spare a dime?" Now, in 1972, it is the scientists, and especially the medical scientists, who have all or most of the money and prestige. It is the humanists who beg for a share of the cake.

Insofar as we are "young humanists in a hurry", we can expect to meet with all the typical responses that Cornford ascribed to the Liberal-Conservatives and the Conservative-Liberals. One of the responses to be expected is, "This is a very interesting proposal, but it is a matter which is too important for an immediate debate and vote

by the faculty. Let us instead appoint a commission to investigate the matter thoroughly and come up with a proposal which is really worthy of this great subject." Commissions, of course, lead nowhere except to the grave, or its academic equivalent, namely, the pigeon-hole or the file where they gather, and turn to, dust. So when you get back to base, and try to implement things that you have heard here, things that seem good to you, and that you want to promote, just beware of that ploy.

Another one that comes to my mind is Cornford's marvelous principle (which surely stands up along with Parkinson's Law or the Peter Principle), namely his "Principle of Unripe Time." That is, everybody agrees that the proposal to introduce human values into the study of medicine is sound. Everybody agrees that the principle is sound, and that the specific proposal is sound and would be very beneficial for the whole medical community. But for any one of a dozen arguments, (and all arguments except one, remember, are arguments against), the time is not yet ripe for implementing it. In today's academic climate of financial stringency, one can hear that argument being produced ad nauseam: "We will do it just as soon as we have the money."

But take heart when all these oppositions arise. Don't lose hope, because we are in fact right about teaching human values in medicine. As Teilhard de Chardin has said about evolutionary progress, "It is enough for a truth to be seen just once, by a single mind, for it to end up by imposing itself on all mankind." After half a century of

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single-minded emphasis on technological advance, the world is ready to welcome some humanistic progress in the practice of the art and science of medicine.

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Institute on Human Values in Medicine

BACKGROUND PAPERS FOR THE SECOND SESSION

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BACKGROUND PAPERS PREPARED FOR THE
SECOND SESSION OF THE
INSTITUTE ON HUMAN VALUES IN MEDICINE

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University of California, Davis
School of Medicine

Prepared by
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Professor of Psychiatry
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I. Title of the Program: Behavioral and Environmental Biology

II. Administrative Relationships: This required course extends over three quarters during the first year and is taught by a multi-disciplinary committee from the departments of behavioral biology, psychiatry, pediatrics and community health. Total time is approximately 60 contact hours. It is scheduled so that it competes with the Molecular and Cellular Biology Course in the first quarter and the Organ Systems Biology Course (combination of gross anatomy and physiology) in the second and third quarter. The course committee is responsible to:

a. An administrative committee for execution, budget, etc.

b. A faculty committee for implementation of faculty educational policy, e.g., content, quality of instruction, etc.

In the first two years, the curriculum is divided into a 20 hour per week required segment ("core") and an elective segment. The students are not required to take any electives but rather use the remainder of the day for studying, recreation or whatever.

III. Rationale: The rationale is to introduce basic (normal) aspects of behavioral and social problems as related to physicians, patients and the medical care system. The course committee interprets this rather liberally and focuses on the social, psychological, cultural and biological bases of human behavior with a desire to introduce material relevant to value systems and ethics in medical practice, represented in both physician and patient. A human developmental model is followed, supplemented by presentation of general social-psychological topics, e.g., healing, medical control of behavior.

IV. Goals and Objectives:

A. The principal goal of the course is to provide the freshmen medical students with the opportunity to view the interrelationship of social, cultural, psychological and biological factors in normal behavior and social behavior. Throughout

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the course the emphasis will be upon the holistic viewpoint of man as contrasted with a view that man is the sum of organ systems. Implications for medical practice are emphasized. Differences and similarities among cultural and socio-economic groups are emphasized and related to value systems, attitudes toward health, etc. Consideration is given the role played by personal and cultural value systems as brought to the medical setting by the physician (medical student), the patient and organized medicine. Real clinical examples are used where possible.

B. During the first two quarters, the course is structured around the developing person, the human life cycle from conception through death, including the phases of gestation, infancy, childhood, adolescence, youth, adulthood and old age. Although consideration is given the "common life crises" emphasis is on the maturational process common to certain groups rather than "fixed" developmental norms or events.

C. Topical areas (as well as the general social, cultural, biological and psychological factors) are integrated into the appropriate developmental stages, for example, "Drug Use and Abuse" is covered in the section on adolescence and youth.

D. Without question our focus is on the medical care situation and human growth and development. Great emphasis is placed on how these factors influence the physician's attitudes, decisions and the patient's growth and access to care. Rarely, is an ethical question dealt with indepth or as a pure problem nor do we commonly focus on the "traditional questions" of medical ethics, e.g., informed consent, therapeutic abortion, etc.

V. Priorities of concern and action:

1. To introduce basic concepts of personal growth as a function of social, cultural and biological diversity.

2. To bring the student's awareness to bear on his own value system and how it affects him in his relationship to the patient, medical practice and the institutions of medicine.

3. To introduce value systems as a differential expression of cultural and socio-economic factors. (We are not specifically concerned with an elaborate exposition of the various arguments concerned with ethical issues as much as we are concerned with the student's awareness of ethical issues in his day-to-day activity and specifically the value systems which may bear on his decisions, attitudes and goals.)

4. Some consideration is given to ethics of specific situations. In this regard there is in this course (and others) brief discussion given to questions of therapeutic abortion, transplantation, informed consent, death and dying. We are not concerned with supplying a final answer to these terribly difficult questions but rather in sensitizing the student to be alert to ethical issues as day-to-day activity and using these as examples.

5. The emerging problem that I suspect will increasingly occupy our attention in this regard is the potential role of the medical profession in transmission of values to or control of others. One immediate example is the use of the medical profession to sanction decisions regarding criminal offenders, i.e., who is bad, who is sick, who needs confinement, who needs medication, who is troublesome, who is ill, etc.

VI. Present and Anticipated Educational Methods: We use audio-visual presentations, reading assignments, lectures, small group discussions, and field trips. From an operational point of view these center around clinical problems so that the student will feel that the discussion is "medically relevant." Frequent clinical examples are used to illustrate the ethical dilemmas as well as the various aspects of normal growth and development. Field trips to key institutions such as local prisons, nursing homes, hospitals, have been extremely successful in bringing a sense of reality to the students.

VII. Content of the Curriculum: The first two quarters are centered around the human life cycle and emphasize normal growth and development as a function of social, cultural, biological and psychological factors. Where appropriate, life crises, e.g., marriage, death, school, job, are emphasized. We attempt to integrate these various parameters around the human task of each life stage. This more or less follows an Eriksonian model but begins with marriage and the family then on to gestation, birth, infancy, childhood, adolescence, youth, adulthood, sex and gender differentiation, aging and chronic illness and lastly dying and death. In the third quarter emphasis placed on broader social issues, particularly centering around the growth and development of the physician and his professional activities, thus, we'll consider topics such as healing from a phenomalogic point of view, institutionalization, communication, cultural and social differences between physician and patient, etc.

In other parts of the core curriculum and in the elective offerings there are opportunities for introducing questions related to human values and medical ethics. An example is an obstetrics elective where the issues relating to therapeutic abortion are

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carefully and thoroughly discussed. In a psychosomatic medicine elective emphasis is placed on considering the whole patient and making "medical decisions" in the context of the social-cultural realities for the individual. Clearly this is incomplete but pending the development of elective offerings specifically oriented to human values and ethical issues this constitutes our program at this time. (An elective devoted to this area is being planned.)

VIII. Resources:

A. People. There are five full time faculty members on the course committee. This committee is charged with the responsibility of design, development and implementation of the course. In addition, there are six small group leaders drawn from the faculty in general that work with the course. Other faculty members are available on request as our outside guests.

B. Time. The course is allotted 20 hours per quarter for three quarters.

C. Space. This has been no problem--we have used small group and large lecture rooms on a schedule basis.

D. Budget. We are budgeted for $3,000 per year for a 100 students. Electives are budgeted separately based on need.

IX. Obstacles: Our core curriculum consists of only 20 contact hours per week with the remaining time available for electives. Thus, the competition for this required (core) course time is keen among the various courses. Those courses that deal with "hard science" have been somewhat doubtful of the merit of the time afforded this offering. There has been unorganized but consistent attempts to capture some of this time or move this course into an elective status. This competition derives from two bases:

1. The time pressure described above.

2. The inherent distrust of behavioral-social issues and their questionable (as seen by other faculty members) application to the practice of medicine.

Another major obstacle has been the organization of this material so that it will be perceived by the student as relevant and viable. Our student body, as most others around the country, is quite concerned about the "relevancy" of the curriculum and also is greatly preoccupied with the social implications of medical education and practice. Thus, organization of this course has been a continuous and nagging difficulty.

X. Allies: We have had good support from the Dean and most of the department chairmen and a majority of the faculty, as well as the Committee on Educational Policy. This support has come primarily from the clinical faculty although it extends in all departments and disciplines. At this time we do not envision any major attack although as noted above this course is always somewhat more vulnerable than others.

XI. Major Decisions: Shortly we will begin to plan next year's offering. The format and content of this has repeatedly been a difficult issue. We doubt that the current is the best design, however, I feel confident that a strong clinical and humanistic approach is absolutely essential.

The development of an appropriate elective to complement this basic course is essential. This elective must contain some more indepth information about the ethical and human values issues, of course, an elective will likely not reach all the students, but on the other hand perhaps we can have a chance to engage those students that are going to be more receptive in the first place and broaden their appreciation for the complexity of these factors.

XII. Methods for Checking and Evaluating the Program: At this point we have no formal method for doing this other than our Office of Medical Education who frequently canvases the students for their viewpoints about course offerings, presentations and content. We have no feedback so far this year.

University of California, Los Angeles

Prepared by
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Associate Professor of Medicine
Chairman, Educational Policy
and Curriculum Committee

It has been the philosophy of the UCLA School of Medicine that the important topic of human values in medicine should not be taught as a special course per se, but rather should be embodied in all of the clinical teaching within the four year curriculum. There are, however, certain areas of the curriculum where this topic receives special emphasis.

During the first year there is a course entitled Group Dynamics which has been designed to enhance student sensitivities towards others and this stresses the importance of considering patient's feelings and also emphasizes patient-physician relationships. The basic introduction to physical diagnosis is also taught during the freshman year and stresses the art, as well as the science, of medicine. Twelve hours are devoted to problems of social and community medicine and during this time there is great emphasis on the human values. The Preceptorship Program, which begins in the freshman year, allows each student to participate with a practicing physician in his routine activities and again stresses the art of medicine, the consideration of patient's feelings, as well as the necessity of viewing illness within the perspective of the whole patient and the relationship to his family and social environment.

During the second year, additional time is spent in the area of social and preventive medicine where special consideration is given to the impact of illness on the patient's family. The community agencies which are available to cope with special problems are visited and studied and the importance of utilizing these facilities in the management of both acute and chronic illnesses is emphasized. During this year, the students also continue their practice of physical diagnosis techniques, again with emphasis on problems peculiar to individual patients and how these problems might affect their physical well-being. The students have their introduction to psychiatry during their sophomore year and there is a course devoted to human sexuality which stresses the inter-relationship between sexual problems and medical illness. This latter course also explores methods of discussing problems with patients and the solution to many common sexual problems.

The third year is devoted entirely to clinical clerkships in medicine, pediatrics, obstetrics, and gynecology, surgery and psychiatry. During each of these clerkships, stress is given to the approach to patient's problems and the necessity of evaluating the entire spectrum of problems which face an individual patient. During this period of time, the students learn primarily by example, and great emphasis is placed on recognition of human values as important to total care. While on their medical clerkship, the students are assigned to a specific faculty member who serves as their "primary physician". Special sessions are held with the primary physician where patients are discussed in detail with emphasis again being on careful evaluation of total problems, and means for solving these problems.

The fourth year is entirely elective and includes both advanced clinical clerkships and depth electives. During this time, students not only have further exposure to primary patient care on the wards, but also have the opportunity to spend time in preceptorships, including rural and poverty areas, where they can have an opportunity to practice medicine in a different social setting.

The Department of Medical History at UCLA is one of the few such programs in this country which awards M.A. and Ph.D. degrees. The rich library facilities and large collections essential for studies in medical history abound at UCLA. Although medical history is not required for medical students, elective time can be utilized for this important humanities discipline. Under the auspices of the department, evening forums including large segments of the medical student body and faculty are held to discuss current ethical and social aspects of medicine.

The UCLA School of Medicine faculty strongly believes that students learn by example and that if the Faculty and House Officers recognize the importance of the human values in medicine and continue this emphasis on a day-to-day basis, the students will get a much broader and more meaningful insight into these problems than they would if an attempt were made to teach these topics in any specific course period.

Duke University School of Medicine

Prepared by
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Health Education

Serious attempts to incorporate the humanities into the Duke Medical School curriculum are currently in the early developmental stages. The ultimate goal is a program of interdisciplinary course offerings coupled with opportunities for directed experience in the area of ethical-legal-medical issues. The Vice-President for Health Affairs has endorsed the concept of such a program.

Duke would seem to provide a rather ideal setting for such a set of offerings. Not only are the Divinity, Law and Medical Schools in close proximity, but there are a number of theologians, historians, psychologists, and lawyers who have carefully studied the medical care system and the issues which confront it from a perspective other than that of a physician. In addition, there is a tradition of student participation in joint degree programs such as the M.D.-J.D. and the M.D.-Ph.D. in medical history.

The Duke Medical School curriculum has the flexibility to incorporate such course offerings. The entire third and fourth year are elective. The sole requirement is that a student take half of his electives in the basic sciences and half in clinical sciences. The courses in the area of ethical issues will probably be approved as clinical electives because of the narrow definition of "basic science" currently being employed.

An interdisciplinary course offered by the Schools of Medicine, Law, and Divinity is to be taught for the first time beginning in the fall term 1972. Students will be awarded three semester credits. Beginning sessions will introduce students to each of the three disciplines, their perspectives and concerns. Following these introductory meetings, formal sessions will be discontinued until the following April. During the four-month interval, students will be working in groups of three, one student from each of the three disciplines, to prepare a seminar presentation, preferably with a case orientation. In the presentation, each student will present a perspective which is not his own. For example, the medical student will present the case from a legal standpoint. It is hoped this will allow the students to experience problems from the knowledgeable lay perspective.

A course titled "Philosophical Problems for Physicians" will be offered as a clinical elective through the Department of Community Health Sciences during the third and fourth terms. The seminar will meet for two hours each week for nine weeks. Students will earn two credits. Placing an enrollment minimum of four and maximum of eight students has been considered to facilitate small group discussion. The following is the description of the course content as distributed to the students:

This seminar is meant to bring the resources of literature, poetry, philosophy, theology and sociology to bear upon specific ethical and philosophic problems with which the practicing physician deals. Each student will be asked to lead at least one seminar; and at least half of the specific subjects will be chosen by the students. Where appropriate and desirable, selected outside visitors will be invited to contribute to the discussion. The following subjects will be among those offered for consideration: 1) Death and dying from the patient's and physician's point of view; 2) Concepts of life and death as reflected in Western Civilization including Judeo Christian, naturalistic, existential and theatre-of-the-absurd views; 3) The problem of pain and the confrontation with horror - relationship between comedy and tragedy; 4) Positive and negative euthanasia - societal and legal barriers to change; 5) Abortion, eugenics and transplantation - ethical implications; 6) Informed consent, the golden rule and the history of auto-experimentation; 7) The ethics of the double-blind controlled therapeutic trial; 8) The idea of a profession; 9) The concept of the quality of indifference as a characteristic of the health care worker; 10) Anxiety and the plight of the individual in a technocratic society. Suggested reading lists for each subject will be provided.

The students taking this elective will all have finished a year of clinical rotations. They will thus have had opportunities to observe or confront many of the issues to be discussed. The majority of students will be seniors taking additional clinical work and hopefully will be able to relate the issues presented to their current patient contacts. One potential difficulty may be that of trying to interest medical students in taking the course. How does one motivate the medical student to realize that devoting time to personal growth through reading, reflecting and discussing ethical issues is as important as time spent investigating membrane transport systems?

An attempt will be made to involve other than medical students in the seminar sessions. The nursing school has shown interest in this elective.

Although the Physician Associates' continuing education requirement has not been completely defined, several PA graduates have also expressed interest in this course.

The weekly "patient care" conference at Duke is another means by which health care workers are able to confront and discuss the ethical and philosophical problems which they face daily on the wards. Each week a different ward is responsible for presenting a patient who is selected because of the issues he or she raises that are not directly related to treatment of systemic disease. The patient's disease, treatment, prognosis, social and physical history, current social and economic situation are discussed. The focus, however, is placed on such problems as dealing with the dying, the management of chronic, severe pain, problems of noncompliance, and maintaining both the physician's and patient's morale throughout chronic, debilitating disease. After 30-45 minutes of discussion by the group, the patient is interviewed. Senior faculty from the departments of Medicine and Psychiatry are always present as well as house staff, medical students, and members of the chaplaincy, dietetic and nursing services.

It is widely contended that the physician has been poorly trained to cope with the health-related ethical problems (from organ transplantation and the definition of death to eugenics) that have been forced upon him. It is generally agreed that a series of lectures will do little to effect behavioral change. A seminar approach which involves reading in depth, reflection, and discussion may be a better way to deal with topics for which there are no "correct" answers. This approach hopefully will provide students with sufficient time and direction to do some serious thinking about some of the major ethical issues in medicine.

College of Medicine, University of Florida

Prepared by
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Department of Community
Health and Family Medicine

HUMANISTIC STUDIES IN MEDICAL EDUCATION: PRESENT AND PROJECTED PROGRAMS

The current offerings in our medical curriculum specifically designed to explore human values in medical education are two. Both are based in the Department of Community Health. In addition, a more comprehensive, far-reaching approach is to be proposed for the entire college shortly.

Dr. Sam A. Banks, Associate Professor in Medicine and Religion in the Department of Community Health, directs the two present offerings. The first is a required seminar on "Human Values in Patient Care" given during the second-year psychiatric clerkship. The second is a large group of course offerings, "Social and Cultural Perspectives in Medicine," from which the student may select during his advanced elective period in the last 18 months of the four-year program.

The psychiatric clerkship seminar on human values was instituted in 1963, shortly after Dr. Banks became a faculty member in the College of Medicine. The social and cultural perspectives program received its first students in January, 1972, as a part of the new curriculum of the college. Both are expressions of the growing conviction among faculty and students that the social studies and humanities offer conceptual tools that can enhance the life and work of the physician.

It is not assumed that the introduction of these studies will lead directly to increased altruism or to a specific value structure. We believe, rather, that the participating students and teachers may gain an increased awareness of (1) their own motives, attitudes and expectations; (2) the way in which these may be expressed in health care settings; and (3) the nature and effect of patients' values upon the physician's thought and action. Specifically, it is the purpose of these courses to:

1. Help the student examine the value issues arising in his patient care, research, and health planning.

2. Sharpen his awareness of the world-views, priorities, ethical positions, role expectations, and methodological assumptions inherent in his (and his patients') activity.

3. Offer settings in which the student can "try on" a broad range of behaviors that can express his values in a constructive meeting with the patient's expectations.

In addition to the immediate problems of individual patient care, problems of social health planning are of primary concern. Strong emphasis is placed upon the manner in which values are embedded in the ongoing decision-making of daily practice, research, and health organization. While the "headline" ethical problems surrounding such atypical occasions as transplantation and genetic counseling may be considered, primary emphasis is given to the more pervasive questions arising in the contractual relationship with the patient; communication difficulties in care settings; dilemmas in allocating time, energy and money, etc.

Teaching in the clerkship seminar takes place in small-group sections, focusing on critical incidents, case studies, and stimulus events designed to elicit the students' questions and formulations. We rely heavily on televised and recorded student-patient interviews, teacher-student role-playing (based upon actual clinical interviews), and game models which give the student a safe arena for examining his values and behavior. Conceptual models and theoretical sources from the humanities and social sciences are introduced as the student can become aware of their relevance to the clinical problems at hand.

The seminar sections meet weekly over a two-month period. These eight-week rotations are comprised of twelve students and continue throughout the year.

The elective program in "Social and Cultural Perspectives in Medicine" is flexibly designed. Students can participate on a part-time or full-time basis for one or two quarters in basic or clinical science areas. The assumption underlying our "basic science" offerings is that the social studies, rigorously applied, constitute an area of basic studies for the physician, just as the biological sciences have for decades.

We offer intense involvement in five basic science areas: psychology, sociology, anthropology, economics, and management, as these relate to health care problems and practice. Clinical science opportunities offering the student involvement in comprehensive health

care are found at a large (60 physician) city clinic; a rural health center; a county mental health center; a community psychological center; a crisis intervention center; and an industrial medicine setting. The student, with his advisors, can select and combine these experiences to meet his individual concerns.

Students participate in research projects, field studies, formal courses, clinical activities, individual studies, and seminars. All students take part in a core seminar in community health, entitled "Health Care Systems and Community Systems." Thus, the student is continually oscillating between an area of intensive study related to health care and a seminar designed to examine that relationship to specific health issues.

In the seminar, students consider concrete instances of interaction between health care systems and family groupings, religious institutions, communications media, political influences, and economic systems. Small-city, rural, and inter-city communities are used as models. The effect of one specific form of health care upon another in the community is explored (for example, the impact of introduction of a private hospital upon the county hospital and regional referral hospital in the same community). Three hour sessions include:

1. "The Use and Abuse of Health Care" (Patterns of need and utilization by health care recipients.)

2. "The Family as Medical Migrant" (Relationship of family systems to health care systems.)

3. "A Doctor's Dilemma: Religious Values, Family Planning, and Abortion" (Relationship of religious systems to health care systems.)

4. "Two Worlds: Medicine and Media" (Relationship of mass communication systems to health care systems.)

5. "The Politics of Mental Health" (Relationship of political systems to health care systems.)

6. "The Local Doctor and National Health Insurance" (Relationship of economic systems to health care systems.)

7. "Wide-Open Ghetto: Rural Views of Health Care"

8. "The Waiting Room: Inner-City Health and Care"

9. "An Institutional Web: Private, County and Regional Hospitals"

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While Dr. Banks and the other participant faculty are funded on state salary lines, the Department of Community Health receives further funding for this and other programs from a joint grant from the Carnegie and Commonwealth Foundations. We count among our strongest resources, the cooperation of our "core faculty in humanistic studies," professors from the Departments of Economics, Management, Health and Hospital Administration, Sociology, Clinical Psychology and General Psychology. These serve regularly as planners, advisors, and teachers. In addition, the Department of Psychiatry has been very supportive in the planning and conduct of the "Values" seminar. Of course, these programs could not exist without the strong support and initiative of the chairman of the Department of Community Health.

As a result of the Arden House Conference of the Institute, our dean and the Education Policy Planning Committee constituted a task force (including medical faculty, law faculty, medical students, and arts and sciences faculty) to explore and design further introduction of humanistic perspectives into the medical curriculum. This committee was funded by the dean and has been meeting regularly since September. We have invited Dr. Danner Clouser, Pennsylvania State University, and Dr. Edmund Pellegrino, State University of New York at Stony Brook, as consultants. We are to offer recommendations to the dean in May, suggesting a comprehensive approach to continuing study of human values in medicine.

In cooperation with the College of Arts and Sciences and the College of Law, we are constructing a grant proposal that would establish a program of carefully selected interchange, orientation, and development of teaching resources among the three schools. Under such a proposed program, professors from the humanities and humanistic social studies would have the opportunity to explore with clinical and basic science faculty and students new ways of introducing their disciplines into the medical curriculum. The major decisions facing us center around this proposal.

The Department of Community Health has placed strong emphasis on building methods of evaluation into educational programs at their inception. Students in the "Social and Cultural Perspectives" program are interviewed by the director during and after their program of study. Faculty working with these students are interviewed along comparable dimensions on a clearly defined format. In this way, we can compare faculty and student views of the educational experience. In addition, the program is subjected to review by the abovementioned core faculty at regular intervals.

The Department of Psychiatry has instituted a regular evaluative procedure in which students have the opportunity to "grade" their faculty and courses. The suggestions derived from this grading process are made available to the instructor of the "Values" clerkship.

In summary, our established programs are under continuing review, and we anticipate that the projected college-wide attempts at introducing humanistic perspectives will provide us with a continuing fund of new views and data that will inform our present attempts.

hundred clinical faculty. The clinical facilities of the College include the Talmadge Memorial Hospital, the Veterans Administration Hospital, the University Hospital, the U.S. Army Hospital at Fort Gordon, the Regional Hospital at Augusta and the Gracewood State School and Hospital.

In addition, there are two colleges in Augusta: Paine College, a Methodist school primarily for black students, has an enrollment of approximately 750; Augusta College, a unit of the University System, with about 2600 students, recently made a four year college.

The Office of Humanities in Medicine

The Office of Humanities was instituted 1 July 1971, staffed initially by two full-time faculty members: Russell R. Moores, a physician, Professor of Humanities and Medicine, and Daniel M. Munn, a priest of the Episcopal Church with specialty in Ethics and Behavioral Science. A third full-time faculty member will be added by fall 1972. The Office is housed in the newly completed Research and Education Building where first and second year medical and dental students spend the greater part of their instructional time. In addition, the Medical College has provided a secretary, funds to begin a library and a modest operating budget.

"Humanities" as defined by this Office includes not only that which is traditionally defined as humanities (Philosophy, Language and Literature, the Fine Arts) but material from the behavioral and social sciences as well. However, our focus in the latter areas is primarily on the implications of the findings of these disciplines for the development, personal and professional, of the future physician.

At present, the Office of Humanities in Medicine is engaged in the following activities:

-Lectures to Phase I (freshman) students in: Normal Human Sexuality; Concept of the Physician (historical and philosophical perspectives); Law and Medicine; Ethics in Medicine; Religion and Medicine; Care of the Dying Patient (the meaning of death and grief reactions)

-Elective courses in the following areas:

Linguistics and Communication
Mysticism
Medical Student and His Environment (a course dealing with student-defined areas of interest)

-Consultative and teaching services to the "16 man project" (an experimental program in medical education)

-Consultative and teaching services to the School of Nursing

-The coordination of MCG's first multi-disciplinary course in Human Sexuality (a team teaching project combining philosophical and ethical, as well as medical and psychosocial, aspects)

-In addition, many medical students see us individually to discuss the meaning of their profession and their place in it

The Medical College of Georgia is convinced of the need of the value of the contribution to be made to the education of physicians from the humanities. This is evidenced by the substantial investment it has made. Our task, then, is not to prove ourselves, but rather to improve the quality of our contribution. Consequently, while we are already providing teaching and consultative services, we feel a major focus of our work at first should be directed toward investigating not only the content required in the development of a humanities curriculum, but also the most appropriate methods of presentation and the proper interface with existing curricula.

For our long range goal we envision a fully developed department providing relevant resource from the humanities to the present and future health care professional.

The Planning Project

The Hypothesis

Traditionally, as indicated in the Prologue, it has been assumed as essential to the proper practice of medicine that the physician be one who is motivated and guided by the highest elements of his cultural heritage. The preoccupation of the profession in the past several decades with the advances of the scientific and technological aspects of his craft - however laudable in themselves - threatens to destroy this perspective to the detriment of the practitioner as a person and to the quality of the service he delivers.

Consequently, it is our aim to restore this perspective to the education of the future physician. Our hypothesis is that a basic core of knowledge from the Humanities should surround and infuse the existing medical curriculum of "basic sciences" and medical technology. And, further, that a significant body of elective material from these areas should be available to the medical student to aid and foster his personal and professional development to the benefit of himself and the society he serves.

The Problem

However valid the insights and praiseworthy the goals of a program of Humanities in medical education, several practical problems must be faced and dealt with before intelligent implementation can be undertaken. These fall into three distinct and interlocking categories:

1) the current state of professional education

2) the responsible selection of appropriate material

3) the most advantageous placement of material and mode of presentation

It is to find solution to these problems the planning project is aimed.

The first problem to be faced concerns the present state of medical education. We are faced with an already crowded curriculum with its inordinate emphasis on observational science and technology. This situation bears an historical burden as well. For not only has the current curriculum developed over a fifty year period, but contemporary faculties have been shaped by it. The result is that the suggestion of the addition of Humanities material to medical training is often met with confused response, if not outright hostility.

Secondly, it must be remembered that the primary function of medical education is to provide a necessary service to the society and a meaningful vocation to the person. Humanistic outlook and technical proficiency must go hand in hand. It would be no gain were we to substitute a broadly incompetent physician where a too narrowly competent one now exists. Therefore, our problem is to discover what from the vast store of knowledge represented by the humanities we should be making available to the future physician while in training. And, further, what of that selected body of wisdom should be required and what elective?

Finally, the mode of presentation of selected material and its appropriate interface with existing curricula must be developed.

For solutions to these and related problems we need several kinds of information from a variety of sources. From this exploration we can develop a program which in content and design is both academically responsible and responsive to the needs of our students.

Project Plan

We propose a 15 month planning project divided into two phases: Phase I, information gathering (12 months); and Phase II, organization of data for program development (3 months).

Phase I

One aspect of the information gathering process will be a review of what is being written about the need for and implementation of programs in humanities and medicine. This will provide a much needed overview of the existing situation.

In addition, we will visit especially promising programs for talks with faculty and students about their reactions to their efforts. One such trip to Hershey Medical School has already proved very helpful.

During the first twelve months also we plan to have consultants in the following areas: Philosophy-Theology, Ethics, Literature, the Fine Arts, Linguistics-Communication, History, Sociology, Political Science-Law and Economics.

After acquainting themselves with our situation through formal and informal meetings with students and faculty, the consultants would advise us as to how they see material from their fields best serving the needs of medical students. We feel these 2-3 day visits will provide the additional benefits of offering important resource to our faculty and students and generate interest in our program.

Another important aspect of Phase I will be information gathered from local people - students, faculty and practicing physicians - regarding the content and design of our program as they perceive the needs and the directions we should pursue. We plan to do this data gathering on two levels. Level one will be comprised of information gleaned from small samples of these populations by means of intensive interview and open-ended questionnaires. Level two procedure will be to sample larger numbers of these populations using close-ended questionnaires developed from the data gathered at the first level. Our plans call for the hiring of a research assistant with a baccalaureate degree in Education whose responsibilities will be to conduct the review of the literature and plan and carry out the data gathering procedures. She will be aided in this by consultation contracted from the Division of Educational Research and Development.

Phase II

Throughout both phases of the project we will be relying heavily on the resources available to us at the Medical College of Georgia in the Division of Educational Research and Development, the Office for Instructional Systems, and the Division of Health Communications. The heads of these departments have expressed keen interest in our program and will be especially valuable in the areas of course design, instructional materials, and curriculum planning.

Phase II will have as its focus the pulling together of the information gathered in Phase I. What we expect to have at the completion of the 15 month project is:

1) A systematic overview of what is currently being done in the area of humanities and medical education, together with a cogent statement of what needs to be done.

2) A program for making available the resources of the humanities to the appropriate student populations at the most advantageous time in course and in the most accessible form.

3) A well-planned program for future growth and development of the humanities curriculum at the Medical College of Georgia.

We feel that the results of this planning project will prove valuable not only to our own institution, but will be an important resource for other established medical schools who are thinking of venturing into this new and exciting area. Assuming the success of our planning activities, we hope to apply for a major Department Development Grant in July 1973.

University of Kansas Medical Center

Prepared by
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MEDICINE AND SOCIETY

For reasons that remain a mystery to me I was asked to describe a program at Kansas having to do with human values in medicine. Perhaps Ron McNeur was simply going 'round the twelve blind men palpating the elephant and it came my turn to describe what I believed was in hand. In any event, I welcomed the opportunity. Blindness is at least forgivable and if indeed I am calling a tail a trunk better to have it pointed out by those far enough away to see before suffering any of the ignominies that can befall a man tugging away determinedly at an elephant's posterior.

I am no authority on the death of God, though my personal observations lead me to accept the alternative suggestion of that Didelphian Oracle and sometime philosopher, Pogo the Possum. With an important exception, unemployment also characterizes the inadequacy of teaching medical morality in medical schools today. The exception is that even if faculties embraced the importance of such teaching, no one would know how best to accomplish it. For that reason I am enthusiastic about new experiments, and opportunities such as this to share them. For the same reason I am certain I share with all of you a salutary skepticism of "right ways," and if there is anything like unquestioning acceptance of what follows, I will be more skeptical than ever.

Medicine and Society is sponsored by the Department of History and Philosophy of Medicine in the School of Medicine. The course provides three semester hours of regular credit to undergraduates in the College of Liberal Arts and Sciences or a three to six-week elective for credit for undergraduate medical students.

The rationale for the course is basically two-fold. First, biotechnical advances have presented society with a heavy, complex, and constantly shifting ethical load which has not and cannot be handled by medicine alone using traditional approaches to medical ethics.

Second, the individual case approach to medical-ethical problems (e.g. a 15-year-old girl wanting The Pill without parental knowledge) avoids easy abstractions and provides theologians, lawyers, philosophers and others a better test of traditional moral guidelines.

Specific goals are included with each assignment, so goals and curricular content can be considered simultaneously.

1) DEATH & DYING -- YOUR OWN (The film "Death" serves as a focal point).
Objectives: To begin to examine your attitudes toward death as a first step in understanding your own fears and becoming more comfortable with your own mortality. To list in order of importance five actions you would take upon learning you had six months to live.

2) DEATH & DYING -- THE PATIENT (The film "Until I Die") featuring Dr. Elizabeth Kubler-Ross is the focal point.)
Objectives: To try to understand the psychological stages traversed by a person coming to grips with his imminent death, and the reasons health professionals have neglected their rightful role in this situation.

3) DEATH & DYING -- THE SURVIVORS
Objectives: A. To identify and understand the more important American attitudes toward death and dying, their origins, the extent to which you share in them, and in what ways they are useful or counter-productive.
B. To assess the family's role in complicating or easing the act of dying.
C. To become familiar with current American funeral practices and balance their role in assuaging grief against the high cost of the "American Way of Death."

4) DEATH & DYING -- THE RIGHT TO DIE (The film "Who should Survive?" is one focal point. Three case histories also are used.)
Objectives: The student should know the main legal and moral distinctions between active and passive euthanasia. He should identify what he sees as different issues involved when the patient is a sentient adult, a sentient minor, a questionably sentient newborn and a comatose individual.

The student should attempt to arrive at his own definition of "dignity" in life, the weight he attached to it, and thereby to make at least a beginning inroad on the question of what kind of death he would prefer, assuming he has some control in the matter. He should identify the ways existing social forces simplify or complicate the matter and how things might be improved. He should ponder which institutions have something to offer medicine in this regard and how their resources might best be used.

5) ABORTION: MEDICAL MORALITY, WHOSE DOMAIN?
Objectives: The student should know the various points in gestation when life has been said to begin and why each was chosen. He should appreciate the logical difficulties involved in defending any one of these points under all circumstances. He should arrive at his own definition of life's beginning and then attempt to reconcile it with his practical views on abortion. He should know the law governing abortion in Kansas and the Kansas experience to date.

6) VITAL ORGAN TRANSPLANTATION: THE SANCTITY OF LIFE MYTH
Objectives: The student should understand the main types of bio-technical advances which precipitated the unprecedented moral issues involved in artificial organs and vital organ transplantation. He should identify and understand the moral and ethical precedents involved and why they are inadequate for the current problems. He should form his own opinion on the propriety of present national priorities and what they should be ideally. He should understand the origins of the concept that life is sacred and decide if it is a man-made myth. Myth or not he should examine the ways in which the concept is useful and counter-productive to society.

7) DRUGS: THE AMERICAN WAY OF LIFE?
Objectives: To understand the different problems presented society by proprietary drugs, prescription drugs, underground drugs. To understand the common and different psychological aspects of each category. To examine the relative potential of education and the law in dealing with these problems.

8) THE MEDICAL ESTABLISHMENT: BOON OR BANE?
Objectives: The student should understand the political structure of organized medicine in the U.S. as well as its relationship to academic medicine, various levels of government and society generally. He should identify what he sees as desirable and undesirable features of the present structure and how it might be improved. To examine carefully the basis upon which a "crisis" has been declared in delivery of health care. To assess the various existing proposals for improving the situation. To understand the system as it works in a socialized country, Sweden. To decide what system might work best in the U.S. and why.

9) HUMAN EXPERIMENTATION
Objectives: To understand the need for human experimentation, the potential for abuse if such experimentation is not properly controlled, and the ethical issues involved in obtaining informed consent and conducting human experiments. To understand the difficulties in certain experiments if the patient is fully informed. The distinction between blind and double blind experiments.

10) HOMOSEXUALITY: THE UNANSWERED QUESTION, WHAT IS DISEASE?
Objectives: To decide the extent to which disease is "real" as opposed to socially defined. To examine the validity of the concept of "impediment" in defining disease, i.e. can we properly label any behavior as disease simply because it prevents an individual from realizing his maximal social potential? To try to decide which segment(s) of society should define disease and which criteria seem most consistently useful.

11) GENETIC MANIPULATION: MEDICINE in 1984
Objectives: To understand the current and future implications of a recent biotechnical development, the cracking of the genetic code. To ponder the ethical problems involved in planning for the consequences of new medical developments even wher those consequences are predictable. To analyze the present relationship between society and scientists, particularly researchers. To decide if social control of applied or research science is possible and desirable and if so, how and by whom.

CONCERN AND ACTION

At this point "Medicine and Society" is not directly action-oriented. It is designed to familiarize students with the nature and complexity of certain problems. Not unexpectedly, perhaps, actions have resulted; demands by medical students for more teaching in human sexuality, for example, and a movement to involve medical students directly with dying patients and their families. But this is action only as action frequently follows knowledge and was not a planned objective of the course.

PRESENT AND ANTICIPATED EDUCATIONAL METHODS

The major educational tool is clinical, i.e. the individual case situation. This avoids abstractions and emphasizes the uniqueness of each moral decision (just as each disease situation is unique). At the same time, since the individual is presented in his social setting, i.e. his obligations to those around him as well as society, one can avoid the easy application of theoretical situational ethics in which the situations themselves are oversimplified.

The cases are presented in the best way possible ranging from written summaries through films and video-tapes to live appearances.

RESOURCES

To date the Course has utilized (other than live case presentations) only Medical Center personnel, to include Protestant and Catholic hospital chaplains. Plans are underway to develop a cooperative program with an innovative local seminary, St. Paul's School of Theology, Methodist.

The program is sponsored by the Department of History and Philosophy of Medicine, which though only a one-man-department, is reasonably well supported by state and private funds.

Unlimited time is available, though in competition with other Electives.

OBSTACLES

The obstacles relate to ignorance and entrenched mindsets rather than active opposition. They include the curricular crush, faculty unawareness of the magnitude of the problem and the resources available to do something about it, lack of active administrative leadership in these areas, and the usual (but diminishing) emphasis on the one-to-one nature of the physician-patient relationship.

ALLIES

Here should be counted time, and an actively developing Department of Human Ecology which is providing a home for such longstanding orphans as medical sociologists and anthropologists. Also there is increasing acceptance of hospital chaplains as consultants on the wards rather than Sunday morning say-gooders. Also, the Seminary affiliation (see 8a).

In reality, the program has more allies than it can use quickly and wisely. Year before last at Kansas a major multidisciplinary effort was mounted de novo concerned with social issues in medicine. It bombed splendidly, and taught us that basically sound "outside" help can fail if the people are not attuned to the minds of the student targets. I know of no way to overcome this except by allowing consultants to gain experience in controlled settings, i.e. working with persons who know the needs of the students involved.

DECISIONS

There are two major decisions, one underway now and one projected. A current concern, as mentioned, is the nature and rate of injecting non-physician experts into the program.

The principal problem for the near future is how large an audience to shoot for. Should all medical students be exposed? The case method, like clinical teaching generally, demands small groups if students are to be genuinely involved. In the future there may be a need for universal exposure to decision-making in medical morality. At the moment I believe more pressing need is to produce a few specialists in the field. Perhaps that is all we will ever need. Sound moral decisions can be made by those who have simply been told what is right. The problem in medical morality now is that we lack even the "theologians" to train the "ministers" to educate the flock. Such specialists are more likely to come from an interested few than a reluctant all.

EVALUATION

Testing is executed only because of University requirements. The exam presents a situation which demands medical-ethical decision, wherein the student must take the best option possible and explain his reasons therefor. Except for the fact that it is one of the few times these students are asked to compose their thoughts logically in writing, the exam is a waste of time. The most important test of the educational process is what the student does with what he learns. For physicians this means observing our graduates in the unsupervised practice of medicine, and except for a couple of feeble attempts, no such studies exist. Regarding medical morality, the problem is even knottier since the physician-testee is more likely to do what he imagines is expected of him while under observation than when alone. So we are reduced to doing precisely what we have attempted to avoid in the case presentation method, i.e. testing abstractions. I would particularly welcome suggestions in this area.

Health Sciences Center
State University of New York at Stony Brook

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The development of a strong and innovative humanities program in the Health Sciences Center was motivated by reasons eloquently set forth by Dr. Edmund D. Pellegrino, Vice President of Health Sciences and Director of the Health Sciences Center, in many other presentations over the past twenty years. As he points out in the Sixth Sanger Lecture, those involved in general university education no less than in the teaching and practice of medicine in all its aspects, find themselves "in the wake of a metaphysical rebellion which on the one hand exalts man and on the other overshadows him in technology and mass organization. Things and services designed for the presumed benefit of man too often end up by dehumanizing him. Man's most daring creations promise to annihilate him as a person unless he can decide who he is, what his existence is for, and where it should lead."

The interdisciplinary faculty now constituting the Division of Social Sciences and Humanities was organized specifically to work in the context of health professional education to enhance and revitalize it, while at the same time providing humanistic and social scientific scholars a remarkable opportunity to study the fundamental issues of human individual and social life in the concrete settings where they arise in the most urgent and poignant way. The questions of values, beliefs, actions, alienation, authority, freedom, constraint, affection, and the like are present in abundance in the health context, for even the most everyday matter of patient care emplifies most of the perennial problems of human life. By addressing these in a variety of pedagogical settings within the health professions, the faculty of the Division has been able to realize, at least partially, this double aim. At the same time, working together with their respective academic departments (with which each faculty member of the Division has a joint appointment) and other university faculty and students, close and mutually enriching educational experiences have begun to develop between the main campus and the Center.

The Present Program of the Division

The present program of the Division is difficult to portray in any usual way (e.g. in terms of courses, course-loads, student loads, etc.), just because the faculty has deliberately attempted to break away from the usual educational models in order to relate its concerns to those of the students and faculty of the Center in terms which seem more appropriate to their respective programs and careers. In general, however, the Division's program thus far has had three main features.

First, a series of full-credit courses and seminars (offered in conformity with the four 10-week quarter sessions of the Center) is regularly offered. These are concerned with topics of significant concern to the humanities and social sciences, but are related specifically to the interests and needs of health sciences students. Thus, students whose programs require study in the humanities and social sciences (e.g. Nursing, Allied Health) are able to enroll in the offerings by the Division within the calendar current in the Center. Other students are able to pursue particular areas of substantive knowledge on an elective basis by taking one or more of these offerings, as their respective programs allow. Additionally, the faculty of the Division has made itself readily available to students desiring to pursue particular topics on an independent study basis (e.g. detailed study of the "doctor-patient" relation through literature, psychology and philosophy).

Second, the faculty participates in the clinical teaching phases of many health science students, and will participate as well in these experiences to an even greater extend as the Center develops and the Division grows. A further word about this participation and its implications might be in order here.

Traditionally, one of the main distinctions, both in faculty and in curriculum, in medical education has been between the basic health sciences and the clinical sciences. The former were conceived as providing the basic scientific concepts needed by students, while the latter were concerned primarily with the application of these to patient care. Inevitably, this distinction resulted in a variety of tensions, not the least of which was competition over that precious and scarce resource, student time. One of the implications of the presence of the Division in the Center is to attempt to reconceive that relationship and surmount the tensions implicit in it. For, if forced to plan curriculum in terms of that distinction, it is plain that the humanities and social sciences would be obliged to make a choice between being placed with either one or the other group, neither of which accurately represents the kind of substantive knowledge which the faculty of the Division seeks to present to students. Accordingly, the Center is attempting to put into operation a different model, one which more faithfully represents the actual tools, skills, and knowledge needed by health professional, and especially medical, students. Differentiating between the different <u>kinds of knowledge</u> needed to become competent, humane and informed health practitioners, we are now attempting to approach these needs in terms of a distinction between issues and themes related to man and the human world, and the ways in which these arise in the clinical settings of medical practice. Thus, just as health professional students require a basic knowledge of human biology, so too do they need basic knowledge of the

creative, philosophical, historical, and social (i.e. the "humanistic") dimensions of man and the human world. Similarly, just as these students must be competent to detect, diagnose, and treat human beings ("patients"), so must they be able to understand the nexus of values, beliefs, life-styles, and the like of their patients and themselves as professionals. Thus, the faculty of the Division will necessarily be intimately involved in both phases of students' education: conveying of basic knowledge and involvement in the ways in which these concepts and data (biological, philosophical, historical, etc.) are applied to people's health and illness.

More concretely, the Division is involved in what is called the "pre-systems" as well as in the "systems" teaching in the medical school (i.e. in the "basic" education as well as in the "application" of basic concepts and tools vis-a-vis each of the organic "systems," and as regards the actual clinical experiences of students). The faculty of the Division is, thus, already deeply involved in the planning and development of both phases of the curriculum. Its actual teaching in each of these phases takes a variety of forms: team-teaching (with Division faculty, as well as with other Health Sciences faculty); advising and working together with faculty and students "on the wards" and in the actual settings of medical care delivery; presenting discussion and question-raising materials in colloquy settings (planned for several of the residency programs at various hospitals); presenting "mini-" seminars on relevant topics for various groups of students; and other, more informal modes of contact. In every case, the basic aim is to bring humanistic and social scientific perspectives and materials to bear on the actual, concrete issues encountered by students in their clinical settings.

Third, the Division has organized several different types of general colloquia already, and expects to engage in this still further. For instance, a "Centerization" discussion seminar was organized for all four quarters this year, to explore the meaning, limits, and range of the Center itself as a "human community." The attempt to bring a variety of health professions (medicine, nursing, allied health professions, social welfare, dentistry, basic health sciences) together as a single, organic unity, has encountered numerous problems, both expected and unexpected. This colloquium provided, at first, an occasion for the airing of many of these, a discovering of mutual concerns, problems, and values, and the beginnings of finding ways of counteracting the divisive tendencies which seem to be inherent in practically any organization as complex as this. The discussion began to focus as well on what sorts of themes are genuinely central to the entire educational venture here, to introduce something of the nature of critical thinking needed to get at (much less to resolve) such issues, and is now involving students and faculty alike in planning future colloquia for subsequent years on topics of mutual concern.

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Still other colloquia and symposia have been given, and others planned for the future. One in particular seems worth mentioning here, even though it proved to be something of a failure at the time. Seeking to involve the main university faculty and departments in the concerns of the Center, especially in areas not now represented by its faculty, the Division assisted the Department of Economics in organizing a colloquium, "Economics and the Health Sciences" presented mainly by members of the Department of Economics. Plans were laid, and the colloquium begun in the third quarter. Despite the evident importance of the topics, and the excellent presentations, few students and faculty were able to participate in the venture--and, accordingly, the effort was abandoned as untimely. Reflecting on why the effort failed, the following reasons seem most salient. (1) The content of the colloquium was not determined with sufficient consultation and negotiation with the faculty of the Schools of the Center, and hence did not address issues about the production, distribution and consumption of wealth that had been sanctioned as important by the responsible health professionals charged with initiating students into professional education. (2) Neither did the colloquium address those economic issues of moment in the informal lives of students (e.g. the concerns of the Medical Committee for Human Rights chapter). (3) In the education of health professions, the "curriculum," at any point in time, is a summary of the state of the struggle for scarce student time. The colloquium was intruded into the educational environment without sufficient attentiveness to this factor, and thus, although a great many students expressed strong desire to participate, they were unable to do so. Similarly, many faculty were unable to do so, due to their multiple other involvements.

Still, the conception of involving university faculty in this way is, by general agreement, desirable, and will be pursued with greater attentiveness to the constraints of time and energies in the future. Among others, the Departments of Philosophy, English, Sociology and Psychology will, hopefully, become involved under the auspices of the Division. Thus, learning from failure, the Division will continue its efforts to be a kind of educational pivot between the main campus and the Center. This will be effected, not only in the way mentioned, but also through the Division's faculty continuing to teach in their respective academic departments, and having its health science courses and seminars open to main campus students for elective credit. It is expected that such interchanges of faculty and students will be mutually fruitful and educationally enriching.

The Present Faculty

The present faculty of the Division includes Professors Rose Coser (Sociology) and Richard M. Zaner (Philosophy), Associate Professor Dan Fox (History) and Assistant Professor Michael Munk (Political Science). As indicated, each of them has a joint appointment with his or her respective academic department and regularly teaches and participates in the life and work of it. Additionally, some of the seminars and courses offered through the Division are also open to main unversity students, and in some cases are joint-listed with one or another university department. The teaching responsibilities of each member varies somewhat, depending on time, other commitments, etc.,but each is involved in a variety of ways other than offering one or more individual seminars and/or courses. Thus, besides teaching in the Department of Sociology and offering a seminar in the Division, Professor Coser also participates with several others in clinical teaching and other seminars (e.g. "Rituals and Symbols in the Health Professions"); in addition to the usual courses in History and the Division, Professor Fox works in clinical settings with Community Medicine, Social Welfare, and is team-teaching with others; similarly, Professor Zaner conducts the "Centerization" colloquium in addition to teaching a year-long seminar on the grounds of human life, and helping to organize the colloquia program.

Other Faculty Activities

Beyond the teaching and research activities in which each of the faculty is engaged, they have been heavily involved in curriculum planning, governance development, appointments and tenure committees, and other significant organizational and administrative responsibilities throughout the Center.

Professor Fox has just been appointed Assistant Vice President for Academic Affairs for the Center--probably the first humanist appointed to such a position of responsibility and influence in any health professional institution in this country. In addition, he has a joint appointment with the School of Social Welfare, has helped to develop curricula for it and for the School of Medicine, and works on numerous other committees.

Professor Zaner, in addition to serving as Chairman of the Division, has consulted at several universities on the humanities in medicine and has helped to plan curricula in the School of Medicine, and serves on several important committees in it and in the Health Sciences Center.

The point of mentioning these activities is merely to underscore the fact that the ongoing program of the Division is only one aspect of the faculty's "presence" in the Center, and that this "presence" is one which has been deliberately built into the Academic Plan of the Center from the beginning. The full involvement of humanities and social sciences, as regular academic disciplines with their own specific substantive content, in the actual context of the health professions, is one of the most important facets of the present program. It also helps to make plain that the continuation of this program, and certainly its further development, will require creating and supporting still other modes of relating to and interacting with the health sciences on the part of humanities.

Problems

None of this should be taken in such a way as to obscure the many and difficult problems in continuing the presence of humanities in the health sciences setting. Not even the fact that the present faculty is deeply immersed in the ongoing planning, organizing, and administering of the Center as a whole should suggest that the faculty of the Division, and its program, meet with no obstacles.

As the sorts of obstacles encountered are revealing both of the character and future of the Division, and the Health Sciences Center, not to mention the profound changes happening in medical education in this nation generally, perhaps these should be detailed somewhat.

(1) Like everyone else, we in the Division have not had the resources anticipated in the Academic Plan and State approval of the initial Health Sciences Center budget requests. But the lack of resources have crippled us more than Departments which, because there is general agreement that one cannot educate health professionals without them, can view delay as temporary. We in the Division cannot be sure we will develop the appropriate critical mass of faculty before the professional schools have so developed their programs, without being able to draw on our resources, that we have to struggle for entry instead of revising and refining obligations that were ours from the inception of the Center.

(2) It is clear, too, that apparent allies are not always one's functional friends when decisions are made. A logical, but nevertheless false, assumption is that faculty of Departments and Schools who applaud our missions and substantive interests are our best friends: for example, psychiatry, community medicine, social welfare, nursing. No criticism is intended of members of these faculties, many of whom are warm friends and intellectual collaborators; as concerned as we to see the strong development of the humanities program. But

the hard fact of current academic life is that when curricular time is allocated, our friends rapidly discover that (a) we are competing with them for the same scarce resource (students' time), and (b) that for teaching purposes we make a distinction between concern for humanistic issues and formal training followed by a lifetime commitment to research and thought about the fundamental questions of the humanistic disciplines.

On the other hand, many biologists and clinicians, despite their occasional skepticism about the importance of what we do for professional education, are quite willing to respect our claims to asking particular questions in a disciplined way on the same basis that we respect their special questions, concepts, and methods.

(3) It should also be noted that our humanist colleagues on the main campus are not always maximally helpful; simply because we are colleagues does not always guarantee support of our efforts in health sciences. Some of the issues here should be mentioned. (a) It is obvious, but for all that still deserving of mention, that even humanistic discipline cannot remove the endemic jealousy of academic people. We in the Division have become purportedly prosperous, according to the rumor-mill, because of our association with demonstrably affluent doctors--a rumor which is patently false. The "high-salary" charge, too, serves as a convenient way to avoid examining the moral challenge implicit in the fact of our lives in the Center. (b) It is realized that we in the Division are appointed to 12-month contracts, but rarely appreciated that this means that we are committed to an 11-month year of teaching, planning and administrative responsibilities. During this time, we still strive to maintain our research and writing projects, not merely to retain our own respective professional credibility, but also to maintain our connections with our "home" disciplines and to continue to explore those issues which individually concern us. (c) Finally, the idea which is given some currency, that our presence in the Center effectively "duplicates" what faculty on the main campus are doing and could easily do for health science students, is in fact a set of ideas in the mind of the beholder. Some of our campus colleagues claim that they are perfectly prepared to teach humanities and social science courses to health professionals--if only they can do it within the limits of a two courses per semester load during semesters that begin in September and end the first week of May.

(4) Finally, it might be mentioned that we in the Division can easily seduce ourselves if we become crusaders for the importance of our role, without constantly acknowledging--in the gut as well as on the lip--that lots of people have important roles in the education of health professionals. The seduction can take many forms: for instance, (a) rationalizations of disappointment which make obstacles

into inevitabilities rather than humanistic challenges posed in new contexts; (b) not making excessive demands on students, so that they will continue to patronize us (pun intended) because in the world in which we live (the Health Sciences Cnnter), rigor and high expectations are correctly equated with centrality to preparation for professional life.

In this respect, it needs to be clear that "humanities" is not a euphemism for cognitive fluff, morally soft sentimentalism, or epistemic bromides paraded as "wisdom." The substantive content intrinsic to humanistic studies, we must constantly remind ourselves, of necessity requires considerable rigorousness, and this must find its way into the actual educational experiences in which we engage. Steps to insure the correct understanding of humanities teaching by our own faculty--articulating "tough-mindedness" into hard curricular terms--have already been taken and will continue to be made an important part of our academic lives.

Modes of Evaluation

We expect to have our program evaluated regularly and from many perspectives. First, the character of the faculty and the Division is such that evaluation is a necessary part of our daily lives. We expect to formalize this daily concern, and have each of our faculty write regular evaluations of his own work, and the program as a whole. In addition, we receive regular evaluative comments from students, transmitted to us by the Schools in the Health Sciences Center, and from a Faculty Advisory Committee composed of members of the various professions represented in the Center.

Second, the Division will, funds permitting, invite a team of evaluators from the Society for Health and Human Values (each of whom is engaged in one or another way in relating humanities and medical education) to review our program. Included in this gruup, we hope, will be at least two persons from humanities departments at other institutions--whose job will be to keep us honest in our work and self-evaluations.

It should be made clear, however, that very few persons, and practically no institutions at this time, can claim to know how to evaluate programs designed to enhance the relationship between humanities and health professional education; there are no generally accepted models or distilled experiences to call upon for this. Thus, one product of our effort here will be the development and testing of criteria for evaluation that emerge from our experience and may have some validity elsewhere.

The Pennsylvania State University
The Milton S. Hershey Medical Center

Prepared by
E. A. Vastyan
Associate Professor
and Chairman
Department of Humanities
College of Medicine

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1. Title of Program

Department of Humanities, College of Medicine, The Pennsylvania State University, The Milton S. Hershey Medical Center, Hershey, Pennsylvania 17033 (to be said without inhaling!)

2. Administration

An academic department with five faculty representing the disciplines of philosophy and ethics; literature; history of science and medicine; political science/public administration and law; and religious studies. The department chairman is responsible to the Dean of the College of Medicine.

3. Expressed Rationale

The intricate inter-dependences of contemporary society and dramatic scientific advances merge in pressing the question of the human context of medical care and medical education. Society is increasingly demanding that such advances "pay off" for man--and for as many men as possible. Questions of values, ethics, priorities, objectives and methods--are thrust to center stage. Many non-medical disciplines have studied man for ages, and know him with some intimacy--his belief systems, his values, his languages, his thought patterns, his life styles. To help in understanding, synthesizing, and applying knowledge for the common welfare, we clearly need the insights, experience and achievements of all those disciplines which deal with man and his institutions. The implications for health and medicine are manifold. Exploring, developing and pursuing such inter-relationships within the midst of medical education provide both a challenge and an opportunity for the humanistic disciplines.

4. Defined Goals and Objectives

A. Some Departmental Goals

(1) To develop a scholarly inter-disciplinary discipline which deals with the overlap of humanistic studies and the life sciences.

(2) To clarify and refine possibilities for the effective engagement of certain humanistic disciplines within medical education generally.

(3) To continue to explore problems and issues of importance for public policy; and to develop paths for involving humanistic studies in such tasks and problems.

B. Some Teaching Objectives

(1) To teach humanistic studies in ways which will help medical students understand and assimilate certain aspects of man's rich heritage; and to employ that in the realm of contemporary ideas, events, problems, and questions.

(2) To help the student see how values, attitudes, commitments and choices are data, both for the learning experience and his own style of life and professional practice.

(3) To encourage open-mindedness, tolerance and understanding of differing ideas, values, attitudes and persons; i.e., to encourage the breaking down of dogmatism.

(4) To encourage reflectiveness in areas of personal, social and professional judgment and behavior; and to help students think with clarity and rigor.

5. Priorities of Concern and Action

The development of effective teaching models and materials, scholarly concern and research in issues of public policy that involve medicine and humanistic studies.

A. Values Questions of Immediate Importance

Many could be mentioned. Fundamental ethical issues--for example, the just use and distribution of limited medical resources; and those involving genetics and behavior modification. Values questions--those which raise the issue and concept of the person; privacy, confidentiality and professional responsibility; prolongevity in medical care, etc. Decision-making processes--with the politics of health care delivery systems being the obvious example, but there are many more.

6. Educational Methods

Mostly small intensive seminars. In each of the disciplines, we have been willing to sacrifice breadth (or its shallow "survey course" substitutes) to strive for some depth with both rigor and disciplinary integrity. In each, an attempt is made to relate the concepts, perspectives and methods of each humanistic discipline to medically related concerns and questions. Methodological differences become important; the insights, concepts and principles of one discipline are brought to bear on disciplines which emphasize different methods. Examples of philosophical analysis, historical discrimination, or theological reflection (for instance) are demonstrated both in contrast and in relation to the methods and models of science and medicine.

7. Curriculum

After trial-and-error experience during the building of a curriculum for a new school, humanities' participation has become multidimensional. But a major thrust remains the discrete courses offered on a selective option: students must complete two courses under the department, but are free to choose among the variety presented. Several of these are interdisciplinary, and all are closely related to the problems, vocabulary and concerns of medicine. Faculty from the department participate occasionally in correlation conferences, clinical rounds, and within the core curriculum. Course descriptions for the past two years are appended.

8. Resources

Initial and quite costly resources were provided entirely by the College of Medicine for the first four years. Last year, the department was awarded a three-year development grant by the National Endowment for the Humanities--making possible the addition of two of the faculty, and three curriculum research assistants, for the formation of a "critical mass". With the state

crisis in funding medical education, the National Endowment for the Humanities grant has been crucial for the vitality and viability of the department.

9. Obstacles

A. Time. Although curriculum time is provided for Humanities, the medical curriculum has continued to expand to overload proportions. Competition for students' study commitments remains a problem.

B. Curriculum planning. A cohesive and commonly accepted core curriculum has not yet been achieved, and imbalances exist.

C. Misconceptions of the role, purpose , and objectives of humanistic studies in medical education remain--and are fairly pervasive. The need for interpretation is constant, and will probably remain so for the foreseeable future.

D. Funding--as a problem that affects the entire College of Medicine.

10. Allies

Developing the department was one of the innovative policy decisions of Dean George T. Harrell, and he has remained constant in his support. Humanities' participation is generally (though often not knowledgeably) accepted. Students who have had good learning experiences within the department usually put that news "on the grapevine," and help generate both student and faculty support.

11. Major Impending Decisions

A. Funding. Competition for monies will increase.

B. Curriculum. The first major evaluation and revision of the curriculum is now being undertaken after repeated postponements and abortive attempts. Decisions will inevitably affect Humanities deeply.

12. Evaluation

As in most sectors of education, evaluation remains a problem. Student evaluations for each course are required; fairly constant but informal peer review of courses takes place.

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THE PENNSYLVANIA STATE UNIVERSITY

COLLEGE OF MEDICINE

THE MILTON S. HERSHEY MEDICAL CENTER

Department of Humanities 1971-1972

The Humanities Program

1. Rather than any required common program of study in Humanities, students will be allowed to choose, among all departmental courses, two as a minimum requirement. Courses usually will meet three hours per week. Students may elect Humanities options at any time during their four years, except that one of the courses must be completed by the end of Year II.

2. Individual study and research may be pursued, with the approval of the department, at any time to fulfill one course requirement. Students will generally be expected to complete one scheduled course beforehand.

Humanities Courses

CONCEPTS OF MAN: Various views of the nature of man will be explored from a theological perspective. The presuppositions, claims and implications of these views will be critically examined. Readings will include fiction, essays and clinical case studies, as well as selections from the works of Martin Buber, H. Richard Neibuhr and Paul Tillich. (E. A. Vastyan)

CONTEMPORARY SOCIAL ISSUES: Leading social issues in a context of humanistic studies, under leadership of the Humanities faculty and with visiting scholars. Such topics as poverty, race, the public consciousness and health care services; science and public policy, will be examined in relation to the profession of medicine. (E. A. Vastyan, Winter Term)

DYING, DEATH AND GRIEF: Ramifications of mortality will be examined through readings in literature, religion and medicine; case studies; and clinical experiences with dying patients. From an examination of mortality and its meaning for persons and cultures, the course will progress to an analysis of clinical problems related to incurable illness; the dying, awareness of dying in the hospital and family setting; mourning patterns; and the course and effects of grief. (E. A. Vastyan, Spring Term)

ETHICS AND MEDICINE: Ethics as a philosophical discipline related to selected moral problems in medicine--abortion, human experimentation, "extraordinary means," genetic control, sterilization, civil disobedience, and value imposition (in psychiatry). Such concepts as natural law, natural rights, consent, action, person, self-determination, and value will be involved. The course will not only seek factual information concerning the specific problems selected, but will also explore the philosophical issues inextricably involved with these problems. (K. D. Clouser)

HEALTH CARE DELIVERY AS AN ORGANIZATION: The primary purpose of this seminar is to introduce the student to the major components of the health care system. Major emphasis will be placed on the private-public sector interface and what the function of government is in the health care delivery system. (J. M. Pierce, Spring Term)

HUMAN VALUES IN MEDICAL CARE: Examination and analysis of religious and moral aspects of issues related to medical care, concentrating on value assumptions embedded in aspects of clinical practice. The course will deal with such issues as principles and problems of professional responsibility; the concept of person in the physician-patient relationship and the health-care setting (privacy, dignity, confidentiality, diagnosis and truth-telling); value judgments regarding sexuality, fertility and family; and the use and role of persuasion in medical care. (E. A. Vastyan)

MEDICINE AND LAW: The interface between medicine and law will be examined in this seminar. General legal principles of torts, contracts and property will be developed and applied to the traditional areas of malpractice, informed consent, etc., as well as to selected special problem areas such as abortion, human experimentation and homeotransplantation. (J. M. Pierce, Fall Term)

PHILOSOPHICAL ETHICS: A critical delineation and examination of the conceptual framework of ethics. Some of the basic concepts, positions, and maneuvers will be developed, and a "complete system" (or two) will be studied in detail. This provides an important framework within which a discussion of "applied ethics" can become more knowledgeable and profitable. (K. D. Clouser)

PHILOSOPHY OF MIND: A conceptual analysis of issues relating to mind and self: such as "mental acts," intention, volition, emotion, pleasure and pain, reasons and causes, mind and body, the concept of person, rationality, and psychological explanation. Those topics most integral to the medical and behavioral sciences will be selected. (K. D. Clouser)

PHILOSOPHY OF SCIENCE: An introduction to the basic concepts of the philosophy of science; such concepts as explanation, discovery, causation, teleology, theoretical constructs, conventionalism, confirmation, and laws of nature. (K. D. Clouser)

POLITICS AND MEDICAL CARE: The political framework in which health care policies are developed will be investigated in this seminar. Traditional aspects of political structure, bureaucracy, powers of government, intergovernmental relations, the budgeting process, etc., and their effect on policy output will be considered. (J. M. Pierce, Winter Term)

POWER STRUCTURE IN HEALTH CARE SERVICES: The political, economic, and social framework in which health care policies are developed and carried out will be the concern of this seminar. The concept of power will be the vehicle used in analyzing the institutional framework within which the physician will pursue his professional career. (J. M. Pierce)

THEORIES OF PERSONALITY: A joint seminar with Behavioral Science, the seminar will consider the Freudian, Neo-Freudian, Ego Psychology and Existential positions. Readings will describe the theories and cite clinical illustrations. This material will be critically analyzed. Issues such as determination vs. free will, clinical vs. statistical prediction, the total vs. the segmented person, the roles of theoretical concepts and of evidence in science are examples of concepts which will be examined. Readings dealing specifically with such theoretical aspects will be utilized. (K. D. Clouser with P. S. Houts, Department of Behavioral Science, Spring Term)

Faculty

K. Danner Clouser, Associate Professor
Pamela DeWall, Research Assistant
Thomas DeWall, Research Assistant
John M. Pierce, Assistant Professor
E. A. Vastyan, Associate Professor and Chairman
Peter Wallner, Research Assistant

Medical Humanities at the University of Texas Medical Branch

Prepared by
Chester R. Burns, M.D., Ph.D.
Director
History of Medicine Division

The University of Texas Medical Branch does not yet have a full-scale program in the humanities. However, dating particularly from the days of Chauncey Leake's deanship (1942-1955), UTMB has had a visible interest in the social and cultural facets of medicine. In 1965, the Chauncey Leake History of Medicine Society was established. In 1969, an academic History of Medicine Division was established, and Dr. Chester R. Burns was appointed as the first director. The Sam Dunn Lectureship on Medicine and the Humanities was also established in 1969. Between 1968 and 1971, approximately $750,000 was spent to acquire significant resources to support teaching and research activities in the history of medicine. In 1970, Rev. Gammon Jarrell, Director of the William Temple Community House, was appointed as an adjunct instructor in religion and medicine. In 1972, Dr. Tris Engelhardt will join the faculty as an assistant professor of philosophy and medicine. All of these activities occurred under the leadership of Dr. Truman G. Blocker, President of UTMB, and Dr. Joseph White, Vice President for Academic Affairs and Dean of Medicine at UTMB.

Between 1969 and 1971, Dr. Burns has engaged in numerous teaching activities including talks to various specialty groups, seminars and lectures in various courses, and self-contained courses (history of the medical sciences; history of diseases; medical ethics). Several students took elective courses in the history of medicine division, and one student won a Logan Clendening Traveling Fellowship in the History of Medicine. Dr. Burns has also participated as a member of the Behavioral Sciences Curriculum Committee.

In April of 1970, a two-day symposium on Medical Humanism, William Osler, and Humanism in Medical Education was held in Galveston. In addition to arranging this symposium, Dr. Burns has designed two exhibits: one on "Rudolf Virchow and the Beginnings of Modern Cancer Research" and one on "Spain and Medicine". Through the generosity of Dr. Chauncey Leake, the Elizabeth and Chauncey Leake Essay Contest in the History and Philosophy of Medicine was established.

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In order to chart a rational course of action, three committees were established at the beginning of the 1971-72 academic year. Dr. Burns has served as chairman for all three committees. One committee has been composed of student and faculty representatives from each department offering graduate degrees in the biomedical sciences. The committee has attempted to define some of the issues that would be involved in establishing learning activities in the history and philosophy of medicine and science for graduate students in the biomedical sciences at UTMB. A second committee, The System-Wide Committee on Medical History, is composed of representatives from major libraries in the University of Texas System, faculty members who teach history of science and history of medicine in the University of Texas System, and administrators. This committee has been designed to establish communication in the System about the development of resources that pertain to the history of medicine and science and the use of these resources in appropriate teaching and learning activities. The third committee--the Medical Humanities Committee--has been composed of student and faculty representatives from the Medical School, Nursing School, and School of Allied Health Sciences, representatives from hospital service areas such as Social Service and Chaplains, and lay representatives from Galveston including a lawyer, a businessman, and the Director of the Galveston County Cultural Arts Council. This committee has been charged with the task of defining problems and issues that must be considered in constructing teaching activities in the humanities for the health professional students in Galveston.

In summary, UTMB and the University of Texas System have been engaged in a year of planning or pre-planning, as you like. Moreover, a complete set of findings and conclusions from these committees is not yet available at the time that this report is needed. Instead of conclusions, the following descriptions will indicate some of the aprroaches taken in each committee and some of the highlights of the deliberations thus far. Although the problems discussed by each committee do overlap, it is best to consider them independently since the focus and emphasis have been different for each one.

Graduate School Committee on the History and Philosophy of the Medical Sciences

The Committee attempted to determine--albeit in an elementary way--the nature of the knowledge represented by "history of science" and by "philosophy of science" and the kinds of skills and attitudes that are associated with this knowledge. Members of the committee gave their personal opinions as to whether or not this knowledge, these skills, and these attitudes should be possessed by basic scientists. After reaching unanimous agreement that some learning activities in the "history and philosophy of the medical sciences" should be a part of the education of graduate students in the biomedical sciences, the Committee made some suggestions about how this material could be effectively introduced at UTMB.

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Certain conclusions can be stated from the deliberations of this committee. Most members of the committee were unaware of the professional developments in the history of science, philosophy of science, history of medicine, and philosophy of medicine during the 20th Century. Some of the members openly admitted that their entire views on history and philosophy had been changed as a result of their work on the committee. In short, basic scientists and their students possess numerous misconceptions about the nature of "history of science" and "philosophy of science". Correcting some of these misconceptions was an important consequence of our committee's activities.

There was unanimous agreement in our committee that teaching activities in these areas for graduate students in the biomedical sciences should be done in a integrated fashion and not in a segregated way; that is, history and philosophy should be offered together and not separately.

The Committee recommended that a course be developed for UTMB graduate students during the 1972-73 academic year. Prior to that, the Committee recommended that Dr. Burns establish careful communication with the graduate students in order to acquaint them with the activities and findings of our committee, in order to determine the kinds of college studies in history and philosophy that the graduate students have had, and in order to determine their educational interests and needs in these areas.

The Committee also recommended that Dr. Burns establish careful communication with the chairman of each department and the chairman of the graduate studies committee in each department in order to acquaint them with the activities and findings of our committee, and in order to develop the resource material pertaining to the particular science or sciences represented in that department which could be incorporated into a broad course of the history and philosophy of the medical sciences, i.e., the outstanding aspects of the historical developments of that science, documentary examples of philosophizing scientists in that field, and the special philosophical problems that are pertinent to that special field(s).

The Committee also recommended that a precise set of learning objectives (cognitive, affective, and psychomotor) be developed for a course in the history and philosophy of the medical sciences; that these learning objectives be correlated with any objectives that may be available from the Basic Science departments and any objectives that may be available from the Graduate School as a whole; that teaching strategies be developed that are consistent with these objectives, and that evaluation procedures be selected that will determine if the objectives of the course are being reached.

The Committee also recommended that all graduate students at UTMB should be eligible to participate in this course, and that those graduate students who satisfactorily participate in this course should receive appropriate academic credit.

System-Wide Committee on Medical History

With the impetus of Dr. William Knisely, Vice Chancellor for Health Affairs, an inter-school Committee on Medical History was created within the University of Texas System. This committee is composed of librarians, teachers, and administrators. The general purpose of this committee is to view the history of science and history of medicine programs within the University of Texas System as a whole and to improve communication among those in the System who are interested in academic programs in the history of medicine and the history of science. More specifically, we hope to provide the basis for some cooperative ventures among those who maintain the excellent but scattered resources that pertain to the history of medicine, the few teachers in this System who may be interested in developing and using these collections, and the students in the various schools who wish to use these resources as part of their learning experiences.

The Committee has held three meetings. During these initial meetings, our principal tasks have been: (1) to identify resource collections (books, manuscripts, "pictures", artifacts) in the University of Texas System and in the state of Texas, that could be used for teaching and research activities, and (2) to identify and define special problems connected with the maintenance, development, and use of these collections of resources. There are general collections in Galveston, San Antonio, Austin, and Dallas that would support any teaching program at the "beginning" level, and there are special collections in Galveston, Houston, San Antonio, Austin, and Dallas that would support teaching and research at an "advanced" level. We have discussed the following special problems connected with these collections: the exchange of holdings within the System, the disposal of duplicates, the restoration and conservation of books, the housing of special collections, the preparation of a union catalogue, "friends of libraries", development of medical archives in Texas, and the need for some guidelines about future purchases and developments pertaining to these resources. Since any serious teaching activity in the history of medicine requires effectively functioning resource "laboratories", this committee will continue to give attention to these areas. During upcoming meetings, though, we shall begin to focus on issues and problems that are central to teaching-learning activities in the history of medicine and science.

Medical Humanities Committee

The activities of this committee have been divided into three phases. During Phase I, we attempted to develop a common understanding, albeit elementary, of the kinds of information, skills, and attitudes which are contained in the following academic "disciplines": religion, philosophy, history, law, languages and literature, arts. With keynote talks by members of the committee and with a common set of readings, we examined the academic possibilities available for those who wish to introduce curricular activities of this mature into health professional schools. In addition to determining the kinds of information, skills, and attitudes that might be introduced, we attempted to determine whether or not--in our personal opinions--this material should be a part of the understanding and expertise of the health professional.

Briefly stated, we agreed on the following oughts. Any health professional who is a religious person will be interested in improving his religious life. Health professionals should be interested in increasing their understanding of the religious beliefs and practices of their patients. The specific skills of professional clergymen should not be assumed by health professionals, but the health professionals should understand the roles of chaplains and ministers and be able to consult with them on a professional basis. Attitudes of empathy and sympathy should be cultivated by every person.

Health professionals should have opportunities to critically examine their fundamental assumptions and basic principles about medicine. They should be cognizant of the philosophies undergirding their activities, and they should be capable of considering the ethical issues of medicine in a relatively sophisticated manner.

Medical history should provide a basis for rational judgment and perspective, a source of inspiration, knowledge and understanding of relationships that are not available from other courses of study, skills that can be used in "taking histories" of patients, and skills that can be used in performing reviews of scientific information in order to conduct research or write papers.

Health professionals should know legal medicine in order to avoid embarrassing or compromising predicaments, to testify properly in court proceedings, and to deal with the non-courtroom aspects of law, such as health legislation.

Health professionals should know how to speak, write, and read the English language well. They should be able to use other languages in order to relate to patients to attend international meetings, to read medicine in other languages, or to practice medicine in other countries. They should have opportunities to selectively read and discuss good literature.

As human beings, health professionals should possess artistic knowledge, skills, and attitudes. In addition to personal satisfactions, the arts may offer specific contributions to the skills of certain medical specialists, for example, art and plastic surgery or psychodrama and psychiatry.

During this phase, certain recurrent themes emerged. For this report, these themes can be best expressed as questions. How will the presence of experiences in the "humanities" contribute to the development of a trained craftsman or the development of an educated professional? Is a professional school responsible for fostering the personal growth of its students? Are the humanities essential to the growth and development of professionals as persons and as professionals? Does the fact that students do take courses in the humanities in college preclude continuing education in these areas during their training process as health professionals? Can a professional school develop learning strategies that foster further developments in those who have already experienced the "humanities" and strategies that will initiate interest in those who have not had significant learning experiences in the humanities? What should be the personal and professional characteristics of a graduate physician, a nurse, or an allied health professional? How will the knowledge, skills, and attitudes that we have discussed create or sustain these characteristics? Can attitudes be taught in a professional school, and if so, how? In relating the humanities to health professional education, can we discover similarities in information, skills, and attitudes that transect the customary compartmentalization of the humanities in colleges and universities? Are there any relationships between studies in the humanities and the development of humaneness and humanitarian attitudes? Insofar as health professional education is concerned, do we want physicians and other health professionals to assume some of the roles of clergymen, historians, philosophers, lawyers, writers, and artists, or do we want them to learn how to relate to these professionals in medical situations? Or both?

Students were not a part of this Phase I. Since this was the first time that laymen were asked to advise about curricular matters at UTMB, a certain amount of stability was desired before students became members of the committee.

During Phase II, we proceeded as follows. A clinical psychologist who sees students as clients and the Director of the Office of Student Affairs at UTMB were asked to discuss UTMB students from the point of view of frustrations, unmet needs, and unsolved problems. They were also asked to give their opinion about the relevance of the information, skills, and attitudes from the humanities to the frustrations, needs

and problems of UTMB students. Students were then brought into the committee as permanent representatives, but they were asked to answer certain questions at the first meeting they attended. These questions included statements about their likes and dislikes about their education at UTMB, about whether or not they would have been interested in learning experiences in any of the "humanities" that we discussed in Phase I, and about the kinds of activities that helped them to be happy and to stay sane. Those responding included a freshman, sophomore, junior, and senior medical student, a senior nursing student, a senior allied health school student, and a pediatric resident. A representative from the Nursing School faculty and one from the clinical faculty of the Medical School then discussed the frustrations that seemed to be prominent in their own lives and among their colleagues. They were also asked to give their personal opinion about the relevance of the "humanities" to these faculty frustrations. Afterwards, four patients were interviewed. They were randomly selected as "common" problems seen by four clinical members of our committee. These included a thirty-eight year old woman who had had surgery for uterine cancer, a four-year old boy who had had recurrent respiratory infections (seen with his mother), a twenty-four year old woman with lymphsarcoma, and a twenty-seven year old woman who had had repeated surgical treatment for congenital anomalies. After a brief presentation by each clinician, the patient was interviewed by the Committee. As additional data during this phase, Al Vastyan described the activities of the Department of Humanities at Hershey. Moreover, the UTMB program in the behavioral sciences and in preventive medicine and community health were described, and attempts were made to discern any correlations that could be made between the "humanities" and these programs in our present curriculum. We thought it might be useful to juxtapose these teaching activities with the problems and needs expressed by professionals and patients.

Our approach during Phase II was somewhat of a backflip. With the conservative, disciplined--oriented approach of Phase I serving as a common point of departure for the group, we embarked on an exploration of the problems, needs, conflicts, and frustrations of both health professionals and patients in a large medical center. We decided not to worry about statistics or absolutely perfect samples. Our objectives for this phase were to (1) learn something about the nature of unsolved problems and unmet needs of patients and health professionals, and (2) to determine if these problems and needs could be solved or satisfied by the information, skills, and attitudes discovered during Phase I. The description of problems and needs was highly personal. Moreover, the judgments about the relationships of the "humanities" to these problems and needs were hypothetical in many instances.

It is extremely difficult to generalize about the data collected during Phase II. Nevertheless, certain conclusions can be stated from the Phase II deliberations. Numerous problems were described which may have little to do with the "humanities". These included the absence of an effective system of communication among the departments, committees, groups, and offices on our campus; the relative lack of coordination of efforts among some of these groups, the peculiarities of our curricular changes and grading systems, the relative absence of group experiences that help students establish significant emotional bonds during their stay on our campus; the highly regimented aspects of a trade school, and the relative absence of graduate-type education; the relative lack of social activities which allow single and married members of a faculty to satisfactorily relate to groups in Galveston; the problem of identifying as a member of a health team; the relative absence of job descriptions in determining faculty roles; and the frustrating lack of focus in trying to balance the ideal demands of research, teaching, and clinical care.

There were some interesting correlations, though, between these problems and needs and the possibilities of teaching humanities. For example, it was suggested that cultural and aesthetic needs among the students would emerge only after elementary and basic psychological conflicts and needs are expressed and resolved. If students and faculty do not have meaningful group interactions in which this can occur, then it is unlikely that the cultural, aesthetic, and intellectual needs will emerge. Another example involves the grading system. As long as students believe that they must compete vigorously for grades--local, state, or national--then they will probably continue to operate on examination treadmills. That is, students will continue to relate in terms of examinations and not in any significantly personal way either to other students, to faculty members, or to patients. Students who do not have a chance to test themselves on a personal basis with others will not profit from learning experiences that are supposed to contribute directly to that personal growth and development.

Even though the humanities might not contribute directly to the solution of some of these problems, most of those who contributed to the discussion of the problems of health professionals--faculty, students, and staff--agreed that learning experiences in the humanities were desirable for the educational programs at UTMB. If given opportunities for such courses, though, the nursing student would have elected more basic science or nursing courses rather than courses in the humanities. Only one of the students felt that the activities in the humanities should be directly related to medicine. One of the students was concerned that his colleagues would abuse the offerings in the humanities and arts, and that they would participate simply for

diversion, amusement, or entertainment--that is, as interruptions in the routine of boring lectures and periodic exams. Two of the students believed that the learning experiences should be optional. The others were non-committal. Some of the consultants believed that any activity that improves the social skills and professional conduct of students is desirable. Too many students, in their opinion, are known for their vulgarisms, unsocial behavior, immorality, and interpersonal crudeness.

The clinician who discussed frustrations of faculty thought it might be difficult to accomplish much in terms of changing the knowledge and skills of health professionals in the areas of the "humanities" that we discussed in Phase I. Although it might be fascinating to understand the legal, philosophical, and artistic areas that are connected with medicine, and although it might be satisfying to possess some of the skills associated with these areas of knowledge, he suggested that attempts to do this would contribute more frustration in terms of the lack of focus of health professional roles. However, he believed that changing attitudes of health professionals toward other professionals in these areas was important. In his opinion, the most important way to change these attitudes is to add those who do have this knowledge and these skills to the campus activities. Once the attitudes of the faculty have been changed in these areas, then the attitudes of the entire medical center will have been improved--especially among the students.

Interviews with the patients revealed the following: (1) the importance of honest, thorough, and accurate communication between the health professional and the patient, (2) the emotional support that can come from sharing one's disease problem with those who have the same kind of problem, for example, in a Tumor Club, (3) the extreme importance of being viewed as and considered as a person during the entire set of experiences involving health professionals, (4) the need for conversation and emotional support during periods of crisis and anxiety, (5) the difficulties of acquiring accurate and consistent historical information from a patient, (6) the difficulties of locating and identifying reliable physicians, especially after moving from one town to another, and (7) the essentially trusting nature of patients. Although the patients claimed that it did not make any difference to them if their physicians were religious persons or played the piano or were artists, one patient was glad that the doctors talked about her art work; one patient noted that the personality of a doctor is very important; and another doubted that a doctor would be professionally competent if he were drinking heavily at parties or running around with various women. In short, his moral character and personality would affect his professional work directly.

At the time that this report was prepared, we were entering Phase III of our committee's activities. This phase will be an attempt to transform the data obtained during Phase I and Phase II into a suitable set of learning objectives, teaching strategies, and evaluation procedures suitable for a significant teaching program in the medical humanities at UTMB

It is apparent from the above that we were unable to answer many of the guiding questions asked by Ronald McNeur. Our program has simply not progressed that far. Although there are limitations to a planning program, it is our belief that the establishment and development of significant and enduring programs of humanitic studies in medical education should be based on thorough and careful planning.

Medical College of Virginia

Prepared by
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Professor of Ethics
Health Sciences Center

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1. The program at the Medical College of Virginia has no official name. It could well be called the Program for Health and Human Values. The title under which the work has been subsumed has been that of the sole professional person employed to supervise achievements in this area: he is a professor of ethics and director of religious activities.

2. The appointment within the past year and a half has changed from that of an "at-large" appointment within the medical college to that of a professor within the newly formed School of Allied Health Professions. While not a separate department within the School of Allied Health Professions, the work in this area has a departmental status. Most of the hours of work, however, take place within the School of Medicine of the Medical College of Virginia.

The Vice President for the Health Sciences Division of Virginia Commonwealth University (Medical College of Virginia) has appointed a Religious Activities Committee which supervises the director's work in this area.

3. The rationale of the program is set forth in the Bulletin of the Medical College of Virginia, Edition- Combined Catalog 1971-1972 thus: "The religious activities program centers about tasks assigned to a full-time faculty member who bears the title associate professor of ethics and director of religious activities. In his pastoral work he conducts services at the MCV Chapel, coordinates the work of the various denominational and faith leaders, and gives advice and counsel as requested by students, staff, and faculty.

"As associate professor of ethics he has teaching obligations in each school at MCV. He participates as consultant, frequent lecturer, and occasional discussant in the classroom, laboratory, clinic, and ward. The term 'ethics' is used broadly to include all phases of religion, philosophy, and spiritual values, especially as these relate to health.

"Being regularly in the classroom, laboratory, and ward he establishes rapport with the students and becomes familiar with the experience through which they go. Through this he maintains effectiveness as a counselor and spiritual leader to those who study medicine and the related health professions. He also comes to new and significant ideas concerning the relevance of religion to health and the influence that health or lack thereof has on the philosophical and religious orientation of a person."

4. The goals and objectives of the program are:

a. Teaching

The program is designed to teach factual material in the area of the humanities. This includes philosophy, religion, literature, history, and something of the fine arts. Hopefully the student will become more broadly educated and find resources that will be meaningful to him in carrying forward the obligations of his profession. In the clinical context this program focuses on the effect of beliefs, value systems, and styles of life on a patient's health situation. No direct attempt is made to shift the philosophical or religious outlook of any student, but the process of each student's considering the relevance of these things on the patient's total condition has a profound effect on all who are involved.

b. Administrative

The administrative goal here is to maintain opportunities and facilities which will enhance the student's growth and development as a whole person. A religious ecumenical center and programming within that center is maintained for that purpose.

c. Pastoral

The director of religious activities has duties also as a chaplain to the students. He counsels, conducts religious services, supervises and coordinates the work of denominational representatives, and performs such pastoral duties as may be requested. This aspect of the work takes the smallest portion of his time. His main emphasis is in the teaching sphere.

5. The priorities of concern and action are:

a. Human value questions of immediate importance

The program here centers about questions involving these topics: abortion, alcohol, autopsies, birth control, decision making (the criteria of), drug addiction, the dying patient, euthanasia, experimentation on human beings, genetic manipulation, care of the handicapped, health care delivery, prolongation of life, rights of patients, human sexuality, suffering, transplants, and questions involving telling of the "truth."

b. Long range questions

Long range questions involve the nature of man and the world in which he lives. What kind of beings are we and towards what goals are we evolving? What manipulations should we make in our environment so as to provide for the health and well-being of future generations? What meaning is there in human existence?

6. The educational methods are:

a. Present

Currently education takes place within the classroom, laboratory, and hospital ward. We also have some outreach into clinics in the community. Lectures are given to the large classes. Small discussion classes are provided for students who elect special emphasis in the area of human values. Discussion of particular patients are held during rounds. Discussions of various research programs and treatment modalities are held in the laboratory areas.

b. Future

Planning for the future calls for expanded opportunities in each of the areas cited above.

7. The content of the curriculum is:

a. An elective course for M-IV students called "The Physician as a consultant on Sex" is provided as a monthly rotation.

b. A course called "Sources of Insight in the Humanities" is provided as a monthly elective for M-IV students.

c. An elective for M-II students called "Value Systems and Medical Practice" is offered on a quarterly basis (two hours one day a week).

d. An elective for M-II students called "The Physician as a Consultant on Sex" (same title as that offered to M-IV students) is offered on a quarterly basis (two hours one day a week).

e. An elective for M-I students called "Ethics of Medical Intervention" is offered on a quarterly basis (two hours one day a week).

f. An elective for M-I students called "The Physician as a Personal Counselor" is offered on a quarterly basis (two hours one day a week).

g. Rounds in the hospital wards of Internal Medicine take place one or two times each week. Each student is expected to report on his patients in terms of beliefs, attitudes, life style, home situation, etc.

h. Rounds in the wards of the Department of Psychiatry are conducted in a fashion similar to those in Internal Medicine (once a week).

i. Teach a monthly seminar in the Department of Patient Counseling.

j. Teach two or three classes each year in the Department of Medical Technology, Hospital Administration, and Nurse Anethetists of the School of Allied Health Science.

k. Give occasional lectures to students in the School of Nursing.

l. Teach classes to the participants in the Continuing Education Programs of the School of Nursing.

m. Teach a course called "Social Aspects of Disease in Man" to students in the School of Pharmacy.

n. Lecture to the students in the School of Pharmacy in the course "Ethical Issues in Patient Care."

o. Conduct conferences on the Dying Patient in the Department of Medical Oncology.

p. Seminars on Abortion Counseling to students in their rotations of Ob-Gyn.

q. Teach a course on Sex Education that is sponsored by SAMA.

8. Resources

a. People

The ethics professor has a full time secretary as an assistant.

b. Money

Funding of half of the salary comes from college monies in this state supported medical college. The other half of the salary and all program costs are covered by an endowment administered by the Medical College of Virginia Foundation.

c. Space

Adequate space has been provided for offices, classrooms, and chapel in the buildings owned by the MCV Foundation: Monumental Church and Teusler Hall. Most of the teaching takes place, however, in the various education buildings and hospitals that pertain to the five schools of the medical center.

d. Time

This program involves a generous portion of the medical school's time.

9. Obstacles: None.

10. The Allied

a. Within the academic structure

This program has received full support of the administration and the faculty. We realize that we are "walking on eggs," as the saying goes, but we have yet to feel any break. The students who welcomed the program from the start seem even more enthusiastic as time goes by (This is our sixth year). The main structured ally within the academic structure is the vice-president's Committee on Religious Activities. The Deans and Department chairmen have been very helpful.

b. Outside the academic structure

The local churches gave a strong initial boost to this program. Advice and guidance came from personnel with the United Ministries in Higher Education. The Society for Health and Human Values, from the days when it was a small committee, has been a chief architect for the program here. This support has been a major factor in our success up to now.

11. Major decisions that must be made are:

a. The decisions

The most important decisions regarding this program have been made. The work load is such that a decision regarding an additional person to work in this field must be faced. Further, we are contemplating the offering of opportunities for continuing education to humanities professors who may desire studying within the medical context.

b. The timing of these decisions

We expect to make some decision on these matters within the next couple of years.

12. Our methods for checking and evaluating the program are:

a. The numbers of students choosing electives in this area has increased markedly.

b. The students are asking the professor of ethics to participate more and more in seminars and activities which they organize.

c. Patients have commented on the "personal concern" demonstrated by many of our students.

d. Testing of factual knowledge indicates that the students have learned many things in this area which were previously unknown to them.

e. Yet withal, the real evaluation of a program such as this take place apart from the Medical College of Virginia, out in the physician's examining rooms through the years to come, out in the various hospitals located throughout the country, and out in the homes of people who have been recipients of the care that our humanities-trained medical professionals have provided.

At the Medical College of Virginia we have devoted much energy to the conceptualization of a fathoming rod by which to compute the boundaries of success, but the real measurement seems to involve factors far down the ocean lane stretched out before us. These distant factors are such that it is difficult to envision them, much less calibrate their separate parts. To report that we are in our halycon days is more pleasant than to disclose the prancing of vicious waves and the snarling snap of Thor's porfundo voice, but the one stae may be no more an ensign of success than the other.

Yale University School of Medicine

Prepared by
David C. Duncombe, Ph.D.
Chaplain to the
School of Medicine

Inception

Five years ago the position of "Chaplain to the School of Medicine" was established on the initiative of an informally constituted Yale Medical Center Committee. The committee saw a need for someone to take direct responsibility for the "human side" of medical education. While this included a concern for the teaching of medical ethics and the counseling of medical students, it was identified most broadly as a pastoral function. The committee wanted someone who would "get to know" medical students and work supportively with their humanistic needs and interests.

Sitting on the committee were a number of Medical Center physicians, the hospital chaplain, a Divinity School professor, two Medical School associate deans and the chairman of the local interdenominational campus ministry board (United Ministries in Higher Education). The committee's task was to sell the chaplaincy idea to the Medical School, to secure the necessary initial financial backing from the U.M.H.E. Board and to locate a suitable candidate for the Medical School's first full-time chaplain.

I came to Yale in the summer of 1967 to fill this post. My previous experience included five years as a boarding school chaplain, some graduate work and teaching (psychology of religion) at Yale, and most recently, a year's clinical training at a State mental hospital. I had no background in medicine, biological science or even medical ethics. Apparently the committee's selection was based on faith alone!

Administrative Relationships

Before dissolving, this committee worked out a very satisfactory system of governance and support for my chaplaincy. I found myself administratively related to four bodies. The U.M.H.E. Board took on the major responsibility for financing and directing my chaplaincy. For them I wrote my reports and came to see myself as one of their three staff campus ministers. Within the Medical School I was listed as "administration" and directly responsible to the Dean. This arrangement provided me

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with an office, a half-time secretary, office expenses and an amazing amount of freedom to shape my own program. To facilitate access to clinical services, I was made a member of the Department of Religious Ministries at the Yale-New Haven Hospital across the street. There I participated as a part-time staff member, taking an occasional turn at night and weekend "on-call" duty and later as a summer clinical training supervisor. Finally, I found an identity as a member of the Yale Religious Ministry, the interdenominational organization of campus ministers at Yale. They functioned more as a fraternal group for me, although occasionally we would cooperate on campus-wide projects.

Initial Direction--Goals and Objectives

Wisely, I feel, I was presented with neither a job description nor a defined set of goals and objectives. My commission was to create these by becoming sensitive to the needs around me. Operationally this meant "doing" little but talking and listening for the first few months. I found myself somewhat of a walking curiosity to both students and faculty at first. "A chaplain in a medical school? What do you do?" The questions were also never hostile or disinterested and I soon found myself answering, "Well I really don't know. What do you think a chaplain should do around here?" Soon I had many unofficial advisors and the beginnings of a program.

One of the earliest suggestions by an anatomy professor involved me more quickly than I expected in medical education. He said he felt "inadequate" answering the questions of first-year students about death and about the many related ethical and emotional issues that arose while the students dissected their cadavers. Would I help? I must admit that I had as many feelings and questions as any medical student in the lab, but this common experience of confronting death (as well as having to study anatomy) began to open doors. Perhaps most importantly, it gave me a feeling for the crushing academic and emotional demands upon medical students and because of this, probably made the task of relating to their needs easier.

As I have gone from table to table talking with first-year students in the years since, I have learned that a medical student's "needs" are complex and change rapidly in this environment. One day a particular student will have an ethical or religious question on his mind, the next day a need to talk about an emotionally upsetting experience. The following day it may be an anatomical problem that most concerns him or he may want to work without any interruption. For a chaplain to be able to pass easily between the humanistic and the technical with reasonable competence best suits this student's needs. It also, I think, allows for the greatest trust to grow between student and chaplain. I have found that my presence in the gross anatomy labs provides me with an invaluable opportunity to get to know each student personally and to have them assess my value to them as they move through later years.

Program

This example is fairly typical of how my program here has evolved: someone (usually not myself) identifies a need, I talk with students and faculty about it, and if it seems significant enough and is not being (or cannot be) met by anyone else, I try to "fill the gap". As passive a posture as this sounds, it has involved me in some rather forthright experiments in medical education. Briefly, here are some of the things I find myself doing this year.

1. Seminar on the Chronically Ill Patient. This course brings together medical, divinity, law, nursing, and public health students around the problems of sustained and terminal illness. Each student is assigned a patient to see each week with the one purpose of attempting to understand "how illness affects his life" in all its physical, social, religious, emotional and often legal dimensions. The students meet once a week in small, interprofessionally mixed groups of five with two supervisors. The idea here is to gain interviewing skills and insights into their patient interviews. One evening every two weeks there is a general seminar for all students on some common aspect of chronic illness.

2. Ethical-theological Preceptorship. A morning a week a theologically-trained psychiatrist and I conduct a preceptorship with third- and fourth-year medical students in the hospital's medical outpatient clinic. Our procedure is to interest individual students in our "approach" to patient care through taking an interest in their patients. Most often we're invited to sit with the student and his patient and observe the interaction. Later we talk with the student, and in a socratic manner, try to discover what was going on of human, ethical or religious importance that he might have missed.

3. Yale Task Force on Genetics and Reproduction. After many student and faculty discussion groups on medical ethics had run out of steam, a poll of former participants showed a desire to "do more than talk" and a topic preference for the ethical problems posed by recent advances in genetics. A year ago two students and I brought together some thirty interested people from medicine, divinity, law and other backgrounds to work on specific tasks. Three projects have emerged with their own task force groups. One group is looking closely at the ethical presuppositions of the genetic counseling in our hospital's genetics and birth defects clinic. Another group is investigating the ethical implications of amniocentesis as an experimental method. The third group is working on a complex scheme of decision making for the screening of heterozygous carriers. The end result of these endeavors will be a report of some kind, possibly in the form of proposed state or national legislation.

4. Medical Committee for Human Rights. M.C.H.R., has provided a good vehicle for involving medical students and faculty in health-related community and national issues. My office has been the organization's chapter office for four years and I have been a chapter officer for as long. My role is one of supporting and enabling (not always uncritically) group effort around controversial issues. For example, M.C.H.R. is presently involved in New Haven with prison health, occupational health and free clinics and on the national scene with health insurance proposals now before Congress.

5. Student Hospitality and Counseling. My office is fairly large and comfortable with coffee always available. Students drop in mostly during the morning either to grab some coffee or to sit around and relax with each other for awhile. My secretary is especially skilled at making students feel at home. Some students stay to talk or to make appointments to see me privately during the afternoon when things quiet down. Student counseling is often around personal issues of marriage or adjustment to medical school, but quite often it is vocationally oriented (i.e., students having second thoughts about becoming a doctor, etc.). The demand for counseling has increased so much this past year that I am now trying to organize ways for students to meet supportively with one another to talk about common problems.

6. Other activities. Spare moments are filled by some of the following: abortion counseling, three research projects (human values in medical education; effects of patient death on surviving spouse; religious significance of binocular rivalry imagery), teaching two divinity school courses and occasional tutorials, speaking engagements (mostly medical ethics topics) in the community, committee leadership for a number of organizations (M.C.H.R., A.C.L.U., S.H.H.V., Council of Churches Religion and Health Commission) and clinical pastoral training (summers).

Additional Resources

Besides the aid of my secretary, Mrs. Darlene Gunn, and Dr. Anthony Allen, preceptor in the medical clinics, this year the chaplaincy has been aided substantially by the part-time services of the Reverend Bruce McLucas. Bruce is Assistant Chaplain, and a first-year medical student. He has provided leadership in a number of projects mentioned above as well as coordinated a used book drive for a medical school in Thailand.

Across-the-board cutbacks by national and regional church bodies supporting U.M.H.E. for three successive years has necessitated a shift in the financial bases of the chaplaincy. Fortunately, my teaching functions at the Medical and Divinity Schools have provided a basis for persuading these institutions to assume partial salary support for the chaplaincy. But with the increasing financial pressures on these schools, there is no guarantee that the chaplaincy can remain funded.

Evaluation

To date, I have had only one formal evaluation of the program. This was done by the Program and Strategy Committee of U.M.H.E. two years ago. The Committee made an on-site visit and met with a number of Medical School faculty. The U.M.H.E. Board reviews my work quarterly through oral and written reports made to them. Academic and clinical training offerings are evaluated by the student and supervisor participants.

Less formally, I have experienced during my five years little difficulty from students or faculty in initiating or carrying through these programs. Relations have been consistently warm and cordial. Occasionally, removed posters promoting M.C.H.R. activities have reminded me that not everything I do or am identified with is uncontroversial or gratefully received. But on the whole, the chaplaincy's greatest difficulty is being perceived as a helpful but relatively "marginal" force in medical education. There is no doubt we see much more of the students during their first "impressionable" year than later on. How to rectify this remains an unsolved problem. No matter how "interesting" or even ultimately important a student sees the human, ethical or religious approach, when he finds himself getting through only half his pathology or physiology each night, even the ultimately important moves to the periphery of his existence.

For this reason other ministers in medical education have chosen a role closer to the decision-making processes that affect the relative weight of curricular values within a medical school. My style of operation emphasizes student ministry in the midst of existing structures instead of involvement with faculty and administration around issues of governance and curriculum change. As the results of our research on the teaching of human values in medical education begins to take shape, perhaps there will be an opportunity to initiate some changes that pervade (and do not compete with) the core medical curriculum.

Conceptualization

I conceptualize my chaplaincy in fairly strategic terms. I take as my model the vision of Kenneth Underwood in The Church, the University and Social Policy. Underwood saw both the need and the opportunity for the church in the university to play a key role in contemporary society. This is the role of bringing to rapidly evolving technical (here medical) knowledge the kind of theological and ethical reflection that would enable the university to become the shaper of social policy for the decades ahead.

For me this means being where the student is struggling to understand and sort out the data with which he is deluged each day. It is not so much teaching in the sense of adding new information as it is suggesting other ways of valuing and sorting out the information he is already learning. In the final analysis, I see the chaplain's job as helping the student become a better medical scientist and practitioner. He does this by calling attention to the great complexity of forces

bearing upon a patient and his illness. I see the chaplain constantly introducing more variables into the picture and socratically raising thorny questions of values, of ethics, and of life and death. Other faculty may do this far better than he, or they may not, but probably no one else sees this as his major responsibility within the medical school.

THE VITALITY AND VULNERABILITY OF HUMANISTIC STUDIES IN MEDICAL EDUCATION

Sam A. Banks, Ph.D.,* and E. A. Vastyan, B.D.**

I. Introduction

The 1960's witnessed the emergence and formation of scattered but significant explorations and programs relating humanistic disciplines and perspectives to the life and work of the medical student. These occurrences have taken many forms: professorships, departments, divisions, required courses, seminars, lectureships, an institute, religious ministries, a professional society, and a growing literature.

Of course, medicine has for centuries raised problems and turned to resources that would be described as humanistic. However, the last ten years mark the emergence of a growing constellation of programs reflecting the influence of humanistic disciplines in American colleges of medicine. The authors of this paper have been both observers and participants in this trend from its beginning.

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This paper was prepared for the Institute on Human Values in Medicine held at Williamsburg, Virginia, from April 26 to 28, 1972, under the auspices of the Society for Health and Human Values. Funds for the Institute were provided by Grant #EO-194-70-4163 from the National Endowment for the Humanities, which also provided partial support for this paper under that grant and through Grant #EO-4579-71-197.

It seems to us that an increasingly receptive climate in medical education--together with a developing clarity concerning the problems, tasks and resources of the humanities within a medical milieu--have brought us to a critical point in the dialogue. Courses and programs established in the relative isolation of separate medical colleges can now be shared. Educational activities created through the influence of individuals may now find embodiment in organizational structures that will outlive their creators. Methods of planning, teaching, and evaluation can be exposed to the critical reflection of colleagues.

An opportunity for such sharing and analysis has been provided by the Institute on Human Values in Medicine. To aid such an effort, we have pooled the observations and understandings we derived from contact with ten varied settings in which diverse forms of humanistic studies have been sown within the context of medicine and medical education:

College of Medicine
University of Arizona
Tucson, Arizona

School of Medicine
University of California, Davis
Davis, California

School of Medicine
University of California, San Francisco
San Francisco, California

College of Medicine
J. Hillis Miller Health Center
University of Florida
Gainesville, Florida

University of Texas Medical Branch
Galveston, Texas

Institute of Society, Ethics and
the Life Sciences
Hastings-on-Hudson, New York

Medical College of Virginia
Virginia Commonwealth University
Richmond, Virginia

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Health Sciences Center
State University of New York
Stony Brook, New York

College of Medicine
The Milton S. Hershey Medical Center
The Pennsylvania State University
Hershey, Pennsylvania

Society for Health and Human Values
Philadelphia, Pennsylvania

While we have limited our descriptive examples to our knowledge of these institutions, a growing number of others have begun developing analogous efforts (Case Western Reserve, Columbia, Medical College of Georgia, University of Virginia, Georgetown, Yale, Harvard).

The following pages are not intended as a comprehensive survey or evaluation of the institutions we discuss. The limits of this paper preclude an adequate assessment of the complex organizational structures and programs found in any one of them. Moreover, since programs dealing with humanistic perspectives in these schools are widely varied, they rely upon different resources, embody different methods, and confront different problems and obstacles. We must, then, emphasize the tentative nature of our generalizations, and recognize, as well, that our findings are a scant sampling at a few points in an expanding process.

Consequently, this paper is a navigational exercise, taking bearings in order to see more clearly our past course and projected journey. This intermingling of our concepts with concrete observations will be grouped under four hearings:

1. Rationale and goals or programs relating humanistic studies to medical education.

2. Priorities, methods, and structures characterizing these programs.

3. Context and impact of such approaches (resources, costs, obstacles, and effects).

4. The decisions accompanying the introduction of humanistic programs into medical schools.

II. Rationale and Goals

A. Changing Tasks and Needs of Medical Students

Programs relating humanistic disciplines to medicine seem to share certain common assumptions about our culture and about the kind of medical student (or physician) required to live and serve effectively in it. In fact, these programs have often taken shape as a response to an expressed need for the education of "new physicians" possessing some additional understanding and knowledge of that society necessary to cope with it as a person, practitioner and researcher.

The physician, as 20th Century man, knows the impact of accelerating technological power, the rapid acquisition and spread of knowledge, and the proliferation and heightened complexity of organizational structures that shape and distort his world. This massive revolution of our time has permeated, ordered and disordered our lives entirely; change has become both our common daily challenge and our sustenance.

Nowhere are the winds of change felt more strongly than in the biological sciences and their clinical application. The explosive power of new knowledge forces constant alterations of professional practice. In this kaleidoscopic environment, the roles and interactions of physician, patient and society have altered rapidly. Systems of giving and receiving health care display increasing variety, richness, and intricacy.

How, then, does one educate a "physician for all seasons," a competent and creative professional able to act and work amid pervasive transformations? Clearly, he cannot be a person at rest. Static models of the physician, embodying traditional skills and virtues, are inadequate for the task.

John Millis stresses two objectives for contemporary medical education, the attainment of skills and the acquiring of knowledge.[1] A third, crucial factor is necessary as well: the development of analytic and reflective expertise, facility in gaining perspective. Today's medical student must learn to achieve footholds from which he can question the assumptions, values, implications, and meanings of his learnings and actions.

Rene Dubos warns that man has not learned to examine the effects of his adaptability, to question and probe the anticipated results of his short-term decisions and solutions.[2] To that end, medical education must be deepened to include those experiences in which the student may gain clarity regarding the

values he holds, internal consistency between his values and actions, and an adequate conceptual framework for decision-making.

He must develop adaptive capabilities: a tolerance for ambiguity, an openness to the richness and pluralism of his world that will break down dogmatism and delay premature closure, and an aversion to oversimplification and reductionism.

B. The Thrust of Humanistic Studies

Semantic kinship has led many to identify humanistic studies with "humanitarianism". Those of us involved in these disciplines know well that we cannot lay exclusive claim to those experiences that are the source of benevolent behavior. Knowledge does not lead, pari passu, to virtue. Moreover, it would be pernicious to suggest that the task of assisting students toward compassionate behavior is the particular and discrete purview of some particular discipline. Such a view leads to abdication of a responsibility that is properly laid on every sector of academic medicine. Humanistic studies are not the "humanitarian ghetto" in a medical school.

What humanities can offer are experiences, conceptual models, and methods of analysis that may stimulate the student's values and understandings; and that may help him to clarify, connect, and criticize them constructively. For this reason, humanistic studies may rely upon and deal with the medical student's curiosity as much as his altruism. When historical sources, philosophical methods, or the concepts from social studies are related to clinical issues and problems, a medical student has an opportunity to mature vicariously, sharpening his question-asking process through the accumulated experience of these disciplines.

At this interface, the humanistic studies and the biological sciences are partners. The primary agenda of science is the production of the future; the humanistic studies gather and probe the funded experience of the past. Together, they enlarge perspective, linking conceptual clarity to the specifics of the concrete situation.

In a time when reductionism is a dangerous luxury, the humanities and social studies can provide a comprehensive context that emphasizes and illuminates, rather than avoids, the complexities confronting medicine. Conversely, humanistic disciplines can gain much needed concreteness and self-understanding through contact with the vital events which are the

focus of medical education and health care.

For the student of medicine, the greatest benefits should accrue as he finds the triad of skills, concepts and values interlaced in his personal encounter with the biological sciences, the clinical sciences, and humanistic studies. He can be helped to see that

> ...today's certainty is tomorrow's doubt... to realize that no 'facts' are beyond questioning and that knowledge is not a fixed set of facts, categories and strategies, but a continuous process of modification, revision, and revolution.[3]

The human being and his human context have been the common and singular focus of both medicine and humanistic studies. Both share a common concern, man himself--his search for meaning; his heritage and hope; his suffering, anguish, defeat and victory; his health, illness, pain and death. Both have a vital role in the professional education of the physician.

III. Priorities, Methods and Structures

A. Priorities: Choices and Consequences

It is inevitable that each institutional setting will develop and adapt its own pattern of priorities and methods within this larger imperative. Indeed, its pattern of priorities will define, in part, its capacities and limitations; the strengths of a particular program may well be the obverse of its weaknesses.

For example, the colleges of medicine at Florida and Hershey have grounded humanistic perspectives in regular academic structures and curricula. In so doing, they achieve a degree of participation, continuity and effect within the life of the institution and its participants. But accompanying this option are the problems of academic territoriality; competition for time, students, and budgetary support; and the burden of administrative responsibilities.

On the other hand, the Division of Social Perspectives in Medicine at the University of Arizona has chosen a different channel. Students have been exposed to a broad spectrum of issues related to medicine through episodic carefully constructed "cameo" seminars, debates, and encounters with visiting scholars. Such a tactic avoids a number of intramural hurdles; there is no need to engage in the contest for course time, or to be vexed

by the territorial ambitions of departments. Episodic educational activity, however, may not provide the necessary reinforcement for significant student learning and change, and there is the further risk of missing the main stream of organizational decision-making. One cannot say that either of these approaches is superior. They do exemplify the importance of establishing priorities with care, and adapting to the strengths and weaknesses of chosen options.

With comparable differentiation, two national organizations have emerged, drawn to the same circle of concern. The Society for Health and Human Values has a primary objective of providing an arena in which issues and values facing medical education can be examined in a national context. Its emphasis is laid upon the relation of these concerns to the educational process in medicine.

On the other hand, the Institute of Society, Ethics, and the Life Sciences provides a singular focus on those ethical questions and normative concerns currently besetting the life sciences. The Institute's chief emphasis is the identification of ethical issues, and the validation of a process of serious, rigorous and systematic attention to ethical questions.

Both groups are concerned with ethics and medical education. However, the Institute participates in the educational process because it is an arena for the exploration of ethical issues. Conversely the Society gives attention to ethical issues because they are integral to the process of medical education.

B. Methods and Structures

Here we can only summarize the organization, functions, and methods characteristic of the ten institutions mentioned earlier. Such programs stand at various stages of development and exist in sharply different contexts, each with its attendant possibilities and problems. Further detail concerning some of these may be found in their self-descriptive reports, prepared for the Institute sessions.

1. The Society for Health and Human Values

The Society for Health and Human Values and the Institute of Society, Ethics, and the Life Sciences represent two complementary but distinct attempts to relate humanistic concerns to health issues. The Society evolved from a group of medical faculty and administrators, ministers in medical education, and related professionals who began

meeting in 1962. From this continuing interaction grew an organization, primarily concerned with the process of medical education and its impact upon man and society, with a current invitational membership of about 100.

The Society's major work is conducted by constituent task forces which have, to date, explored issues surrounding human experimentation, consumer expectations, concerning health care, the place of humanities in the medical curriculum, the role of women in the health sciences, the relationship between the campus minister and colleges of medicine, and changes in medical students' goals and attitudes. An executive council coordinates the Society's functions, and an annual meeting, lectureship, and program are held at the time of the Association of American Medical Colleges' conference.

Funding has been received from a number of sources, including the National Endowment for the Humanities, United Ministries in Higher Education, and the Russell Sage Foundation.

2. The Institute of Society, Ethics and the Life Sciences

The Institute of Society, Ethics and the Life Sciences was founded in 1969 under the direction of Dr. Daniel Callahan. It has received financial support from John D. Rockefeller, III, the National Endowment for the Humanities, the Rockefeller Foundation, and others. Its goals are three:

1. To study ethical considerations and processes in the areas of (a) behavior control, (b) death, (c) genetic counseling and engineering, and (d) population expansion and control.

2. To teach (and do research regarding teaching) in four settings and interdisciplinary combinations of these settings (Columbia University College of Physicians and Surgeons; Columbia Law School; Union Theological Seminary; and The State University of New York at Purchase).

3. To have some impact upon professional and policy-making groups, serving as a "broker" of information on ethical issues.

The Institute maintains four permanent research groups, each containing a staff person, a senior chairman, and "fellows" who serve as participants. Each group deals systematically with one of the ethical problem areas mentioned above.

In addition, the Institute contracts with the educational organizations mentioned above to provide programs relating ethical processes and issues to theology, medicine, law, and undergraduate fields of study. The program in medical ethics at Columbia University provides offerings in all four years of the medical curriculum. It will administer summer programs (two to three weeks in length) on these concerns at Dartmouth, and will offer an undergraduate program on ethics in the college's summer school. Funding for the teaching projects has been stimulated by the Institute, largely through grant support. The organization distributes an effective newsletter, The Hastings Center Report, and a wide range of reprints on ethical concerns.

3. The University of Texas Medical Branch

The University of Texas Medical Branch is attempting a process of careful, rational planning for a medical-humanities education program. In 1969, Dr. Chester R. Burns was appointed director of a new established Division of the History of Medicine; and the Division soon widened its interests beyond historical studies by establishing a planning committee on humanities in medicine, composed of a diverse constituency. The committee's studies form three phases: (1) the nature of humanistic disciplines as a resource; (2) the needs of students and patients as they may be related to these resources; and (3) the transformation of these data into objectives, teaching methods, and evaluative procedures for a humanities program.

4. University of Arizona

At a different stage of development from Galveston, the University of Arizona College of Medicine has an established program entitled the Division of Social Perspectives in Medicine. Founded by Dr. Richard Willey, the Division is an institutional rather than an academic organizational unit, responsible directly to the dean. Established in 1968, it has devoted attention to carefully planned seminars on "Cultural Horizons of Medicine," lasting from one to two days. Representative topics include the following:

"Medicine and the Southwestern Culture"
"Medical Care: A Privilege Becoming a Right"
"Death and the Doctor"
"Experimentation on Man"
"The Rights of Children"
"The Control of Brain, Mind, and Behavior"
"The Borderlands of Treatment"
"Who's Changing the Medical Contract?"

Through its seminars and discussion-debates, the Division has served "enabler-broker" roles, identifying issues and finding the occasions and resources for their study. Attention is now shifting to greater involvement with the faculty in exploring subtler issues in the shaping of medical education. New developments include the appointment of a professor of medical jurisprudence and a professor of anthropology. Each gives substantial time to activities other than formal academic concerns, the former as legal consultant for the hospital, and the latter to a Med-Start program designed to motivate and support minority groups entering the health sciences. Also new is a "Visiting Scholars Program" in which departments (with the approval and financial support of the Division) may invite authorities on the history of ideas affecting the evolution of that particular medical discipline.

5. The Medical College of Virginia

One of the early experiments, the Medical College of Virginia's program, was instituted in 1966 when Dr. Glenn Pratt was appointed to a double position--professor of ethics and director of religious activities. In the first role, he has served as lecturer, seminar leader, and consultant in both required and elective courses, and during hospital ward rounds. Recently his work was incorporated within a newly formed School of Allied Health Professions, though most teaching continues to be done in the School of Medicine.

While the role of director of religious activities provides additional opportunities for student contact, it also imposes additional time demands and certain ambiguities of extra-academic relationships. Such multiple duties and demands inevitably become strains on both the concentration

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and care that can be devoted to specific concerns. Consideration is being given to the appointment of one additional person.

6. The Pennsylvania State University

Established as probably the first academic department of humanities in a college of medicine, the Hershey program was begun before the first class for that new school arrived in 1967. Initiated with three disciplines, the department now contains faculty positions in history, literature, philosophy, political science/public administration, and religious studies.

Major effort has been placed on the development of courses representing these different disciplines, but closely related to the concepts, problems, and concerns of medicine. Students must select two course offerings from the department during their residence. Among the more effective options developed are courses in Ethics and Medicine, Medicine and Law, and one titled Dying, Death and Grief.

The department was awarded a development grant of $258,000 by the National Endowment for the Humanities, which made possible the expansion of the faculty from three to five. Funds were also provided for the development of teaching materials, and their eventual dissemination for possible use in analogous programs at other medical schools; and for several consultations and conferences on related areas.

7. State University of New York, Stony Brook

Under the leadership of Dr. Edmund Pellegrino, Stony Brook has planned an extensive (twenty-faculty) Division of Social Sciences and Humanities in the Health Sciences Center under the chairmanship of Dr. Richard M. Zaner, a philosopher. All faculty members will hold joint appointments in both the Health Sciences Center and appropriate department in the College of Arts and Sciences. The SUNY program is designed to invert the usual approach to medical education, in which the liberal arts precede the medical sciences and are taught at an undergraduate level. Humanistic studies will be introduced at appropriate points throughout the entire medical education process.

Faculty will offer both required and elective work, and it is assumed that the faculty members will have unusual depth of experience in their several disciplines. Current positions include professorships in philosophy, sociology, history, and political science. Additions in medical ethics, literature, law, anthropology, and economics are planned.

The divisional structure is designed to cut across traditional departments, linking the work of humanists and social scientists with clinical and basic science offerings through integrated team teaching. Nursing and other health professionals also participate in the flexible educational format. In addition, the Division is seeking NEH funds to establish fellowships and residencies for representatives of the humanities, social studies, and health sciences.

8. The University of Florida

At the University of Florida, courses relating humanistic perspectives to medicine have been taught continuously since 1963. At present, these emphases are located primarily in the Department of Community Health. Under its auspices, a required seminar on "Human Values and Patient Care" is offered to small-group sections of medical students on the psychiatric clerkship rotation. In these sessions, video tapes, recordings, one-way glass, role play, and game models are used to allow the student to examine in depth the values implicit in his and his patients' behavior.

During the last 18 months of the students' curriculum, the department offers multi-track selective programs in "Social and Cultural Perspectives in Medicine." During this period, the student may choose to take up two full quarters of seminars, field work, individual study, and other courses relating anthropology, sociology, economics, management, and psychology to health care problems in the community. Departmental faculty include representatives from theology, psychology, and anthropology, as well as clinicians. A significant emphasis of this program is the teaching of students in systematically varied community settings, requiring reexamination of their former attitudes and approaches to health care.

In May, a faculty-student Committee on Humanistic Studies in Medical Education will present the results of an extended study to the dean, proposing the establishment of a "Center for the Relationship of Medicine, Law, and

Humanistic Studies," sponsored by the Colleges of Arts and Sciences, Medicine, and Law. The Center would provide a vehicle for the selection, orientation, and introduction of faculty members engaged in cross-disciplinary study.

9. The University of California, San Francisco

Not only humanities programs, but also colleges of medicine stand at various stages of development, often determining the shape of dialogue with humanistic studies. The University of California at San Francisco is marked by strong departmental structures, and the main thrust of its curriculum remains basically traditional.

A number of significant innovations and changes have been made, however. An inter-college course entitled "Social Aspects of Health and Disease" has been instituted. In the basic psychiatry clerkship, Dr. Leon Epstein and his staff focus on values issues in crisis interactions, and have developed many audiovisual teaching materials. An interdisciplinary team has been meeting weekly to examine the ethical ramifications of San Francisco's extensive renal dialysis and transplantation program.

Dr. Otto Guttentag and Dr. Chauncey Leake, regularly lecture and write about philosophy and history; and Dr. Anselm Strauss, Professor of Sociology in the College of Nursing, has done extensive research which has stimulated concern for ethics and values in the care of chronic and terminal patients. The Department of Community and Ambulatory Medicine has provided focused concern on the social and human context of medical care.

Plans were laid for the establishment of a School of Human Biology, which would provide faculty and courses in humanistic and behavioral studies for the other schools. Since funds have not been appropriated, there seems to be little hope for the project at this time.

10. University of California, Davis

In contrast to the San Francisco campus, the new School of Medicine at Davis offers a largely innovative curriculum, with stress on an organ-systems-oriented, heavily elective educational experience. Committee teaching

is the rule in the core courses, and emphasis is placed upon the students' participation in clinical and research problem solving.

The two primary entry points for humanistic perspectives are the first-year core sequence in "Behavioral and Environmental Biology" and the elective possibilities found in the succeeding years. The first two terms of the sequence are devoted to concepts of human development as these relate to health and health care, while the final term touches upon such varied fare as health maintenance, problems of dehumanization in medicine, racism and sexism in health care, and current health care delivery systems.

IV. Context, Impact, and Cost

With varying degrees of assurance, certain generalizations can be drawn from such diverse relationships between humanistic studies and medical education:

1. Such programs, though expanding quite rapidly while in experimental stages, should be considered as prototypes of function rather than structure. While the range of structure is broad indeed, their effectiveness seems clearly bound to certain methodological commitments. Organizational and teaching methods must overcome the stereotypes of humanistic studies as simply broad, vague, and shallow. To contribute effectively to medical education, the teaching of humanistic studies must be marked by conceptual rigor and continuity.

2. Both concentration and clarity are requisite. Purveying of large amounts of information can remain the unenviable task of the biological and clinical sciences; the humanistic disciplines may cheerfully abdicate such a role, and should strive instead for the careful and concentrated presentation of concepts, models, methods and affective experiences. As a corollary, however, shallowness should be fiercely shunned; the temptation is often "to do something, and not nothing", but to try to do something about every problem, question, challenge and demand can easily produce only dissipated impotence and ineffectiveness. For this reason, the typical introductory, survey-type course is a poor "hunting ground" for humanistic studies.

3. On-site presence is requisite if humanistic disciplines are to be vital contributors to the processes of medical education. Education does not occur simply among individuals; rather, it takes place within a highly-charged and complex

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social milieu of work and learning. To become functionally effective, humanistic studies and perspectives must become part of the social system of medical education.

4. Any effective teaching of humanistic perspectives to medical students must be centered around the events, problems, and practices of health care. To attempt to call the student away from these concerns is to work against the grain of his motives and self-understandings and of the reward system in which he lives.

5. The introduction of non-medical perspectives into a medical context is not a self-validating enterprise. Rather it is akin to what Robert Penn Warren called "that slow, painful grinding process by which alone an idea takes shape in history". Effectiveness exacts a toll of energy, money, time, and the support of knowledgeable and committed medical colleagues. Without such resources, the medical school can become the burying ground for the brightest of visions and ventures.

6. Particularization is mandatory. Contexts vary widely, from San Francisco to Yale, from Davis to Virginia. It may be foolhardy to institute a Department of Humanities at Arizona. Local conditions may require such an organizational structure at Stony Brook. Diverse approaches have been demonstrated; local adaptations are clearly crucial.

7. Such humanistic studies face potential opposition in medical education from three identifiable directions. Colleagues from the humanistic disciplines can be expected to look askance at such attempts as marginal, withholding conventional academic rewards. Secondly, medical colleagues may well resent the implicit criticism and challenge of alien disciplines, whose presence questions the adequacy of traditional models. The humanist and social scientist are third parties whose comments on clinical interactions may transform the student from imitator to questioning learner. Finally, the biological scientist, competing for student time and attention in a constricting curriculum, may see the humanistic disciplines as uninvited intruders or unwelcome guests.

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V. Impending Decisions

The preceding section outlined some of the inferences we have drawn from the emerging programs described. Our experiences also indicate that there are other knotty problems pressing for decisions, and the particular modus vivendi of each institution will require localized choices and solutions. Among these problems, three seem to be common to all such ventures, and deserve examination in brief detail.

1. What do we mean when we speak of the "humanities"? The scope of this term varies from school to school. At Hershey and Galveston, social studies are largely grouped within separate academic structures, while Florida and Stony Brook attempt to include such disciplines as psychology and sociology within the humanistic studies.

   Such questions are not merely academic juggling. They reveal the degree to which social perspectives can be introduced through the concerted action of the so-called "humanities" and "social sciences". Is anthropology a "behavioral science," and "humanistic study," or both? The methods of teaching, grouping of faculty, and selection of students will be reflected in our choices. If behavioral sciences and humanistic studies are to coexist in a medical school as separate entities, we need to determine the "ground rules" of that living arrangement. If social psychologists and philosophers are to share goals and methods in a department, what is their common ground?

   This question is further compounded by considering the relation of law and economics to the traditional humanities. Programs at Florida, Arizona and Hershey are struggling with this issue in different ways. To introduce such varied fields to the medical student in unrelated fashion may fragment their impact, waste valuable resources through duplication, and engender territorial struggles for teaching time.

2. A second decision confronts us: what kinds of teachers are required for these new tasks? If humanistic studies in medicine are to win the support of the academic community, the scholarly and educative functions cannot be carried out in a part-time, peripheral way by one whose

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main interest lies in another clinical or research discipline. On the other hand, a competent humanist may be an ineffective teacher in a medical setting if he lacks knowledge and experience of that environment. A new blending of two forms of expertise seems necessary: grasp of a humanistic discipline and acquaintance with the medical milieu. As Clouser suggests,

> We can at the same time imagine a finely honed interdisciplinary 'specialty' developing, that is, a specialty in the interrelation of the humanities with the medical world.[4]

3. A third decision demands attention: selection of a target population for teaching. At what stages of medical education are humanistic resources most needed? When, in his professional education, is the physician-student most responsive to these issues and perspectives? When will he be able to translate insight into action most effectively? While we have spent our greatest efforts on the medical student, we may well consider the premedical period, internship and residence experiences, and continuing education for the practicing physician.

The difficulty of these decisions and choices underlines the need for sustained, intensive planning among the humanistic disciplines, and clear conversation between these fields and other medical faculty. Such interaction can avoid the pitfalls of tokenism, sentimentalism, and nostalgia. Donald Bates say succinctly, "Token courses, given by people with token knowledge in the humanities, social sciences, or whatever, will not serve the interests of humanism."[5]

Even complex tasks build upon rudimentary beginnings, and this paper represents but a start toward the careful examination and evaluation that such programs now warrant. We have attempted to draw certain basic principles and common generalizations from the selected, concrete examples of humanistic studies in medical education. Our primary focus has not been on settled conclusions, but rather upon a rapidly moving process--one which we believe is marked by both the vitality and vulnerability of new life.

Footnotes

[1]John Millis, A Rational Public Policy for Medical Education and Its Financing, New York, National Foundation for Medical Education, 1971.

[2]René Dubos, Man Adapting, New Haven, Yale University Press, 1965.

[3]K. Danner Clouser, "Humanities and the Medical School: A Sketched Rationale and Description," British Journal of Medical Education, Vol. 5, No. 3 (September 1971), p. 227.

[4]Ibid., p. 230.

[5]Donald Bates, "Humanism in Undergraduate Medical Education," Canadian Medical Association Journal, Vol. 105 (August 7, 1971), p. 260.

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University of California, San Francisco
(Supplementary Report)

The following is a supplement to the reported activities at the University of California, San Francisco.

The main course, which Dr. Guttentag offers, entitled The Medical Attitude, focuses on an analysis of the axioms of medicine in terms of ontology, "What does it really mean to be a physician?" The course starts with a definition of medicine as care of health of human beings by human beings, and proceeds to a definition of man as a physical being of finite freedom, discusses the physician-patient encounter from these points of view, and analyses old and new problems in medical care in terms of man's inalienable finite freedom. Problems of philosophy proper as they evolve in the course, e.g. finite freedom, care, etc., are discussed by a general philosopher, Professor Edward Hobbs, Professor of Hermeneutics at the Graduate Theological Union in Berkeley and Lecturer at the Medical School. Doctor Guttentag is an M.D. His title is Professor of Medical Philosophy. He holds appointments in the Departments of Medicine and History of Health Sciences.

The course The Medical Attitude is an elective seminar course. It is also offered in the Graduate Division and in the School of Nursing as well as in the School of Medicine. Students who have taken this course may take another one in which selected writings in the philosophy of clinical thought are read and discussed.

Another activity centering on the San Francisco campus is the Collegium for Human Values in the Health Sciences, an informal group of scholars in medicine, law, theology, and philosophy of various campuses of the Bay Area. Members present papers on the ethical and cognitive problems of medicine as such problems arise in the various areas that the members of the group represent or as they are requested by other groups, e.g. the Committee on Experimentation on Human Beings on the San Francisco campus.